

**ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM**

Held via Zoom

**On Tuesday, 2 June 2020 at 10am**

Before: Ms Penny Armytage (Chair)  
Professor Allan Fels AO  
Dr Alex Cockram  
Professor Bernadette McSherry

Counsel Assisting:  
Mr Stephen O'Meara QC  
Ms Georgina Coghlan  
Ms Fiona Batten

1 THE CHAIR: Welcome to the Royal Commission's discussion  
2 on enabling a contributing life.

3

4 I'm Penny Armytage, the Chair of the Royal Commission  
5 into Victoria's Mental Health System, and I'm joined by my  
6 fellow Commissioners, Professor Allan Fels, Alex Cockram  
7 and Professor Bernadette McSherry.

8

9 On behalf of the Commission I acknowledge Aboriginal  
10 peoples as the traditional owners across all of the lands  
11 on which we locate for today's panel discussion, and I pay  
12 my respects to their Elders past, present and emerging.

13

14 Firstly, I would like to extend my sincerest thanks to  
15 Dr Sarah Pollock, Dr Michael Fotheringham and Ms Catherine  
16 Humphrey for taking the time to participate in today's  
17 panel discussion.

18

19 I know that you have dedicated a significant amount of  
20 time and effort into developing your comprehensive witness  
21 statements and preparing for today's discussion.

22

23 The Commission recognises that a contributing life can  
24 mean many things to different people. During last year's  
25 hearings the Commission heard from Janet Meagher AM who was  
26 actively engaged in the development of the National Mental  
27 Health Commission's Contributing Life Framework. Janet  
28 defines a contributing life as:

29

30 *A life that is fulfilling, enriched by*  
31 *close connections to family, friends and*  
32 *our communities of choice.*

33

34 In her witness statement, Janet highlighted a range of  
35 factors that can assist people to live contributing lives  
36 including:

37

38 *Having a home, having something meaningful*  
39 *to do, improving opportunities, obtaining*  
40 *good personal health, having healthy*  
41 *relationships and having adequate mental*  
42 *health and social supports.*

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44 Given the complexity and enormity of the issues in  
45 Victoria, today's discussion will have a particular focus  
46 on the topic of housing and homelessness for people living  
47 with mental illness.

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The Commission is aware of the scale of housing and homelessness issues in Victoria. The statistics about the lack of safe, secure and affordable housing stock in Victoria are particularly striking, as is the heightened impact of these issues for people with mental illness.

The Commission understands that there are, according to the Australian Bureau of Statistics, currently an estimated more than 24,000 Victorians experiencing homelessness and, according to the Parliament and Victoria's Legal and Social Issues Committee, more than 80,000 Victorians on the waiting list for social housing.

The Australian Institute of Health and Welfare also estimates that more than 30,000 Victorians who were Homeless Support Service clients in 2018 were recorded as having a current mental health issue.

We understand that this issue impacts many Victorians. We are also acutely aware of the complex bidirectional relationship that exists between poor mental health and housing and security.

Existing evidence tells us that people with mental health issues are significantly more likely to experience housing challenges or homelessness and vice versa.

The Commission has consistently heard that, while housing alone is not sufficient to effectively and fully support someone with mental illness, access to secure and appropriate accommodation is a fundamental component of recovery.

One individual who attended our community consultations in St Kilda noted that:

*I don't understand how you can have stable mental health if you don't have stable housing.*

We also understand that this issue is experienced differently by different people, affecting consumers, their families, carers and loved ones.

While we acknowledge that there is a critical need for stable housing for all Victorians, our terms of reference

1 are clear that our inquiry is to focus on Victoria's mental  
2 health system.

3  
4 As a Commission, we understand that we cannot resolve  
5 all issues in the housing and homelessness sectors,  
6 including the current shortage of social housing stock in  
7 our state. But to the extent to which it is possible  
8 within our remit we are considering opportunities to drive  
9 meaningful reform for Victorians experiencing both mental  
10 illness and housing and homelessness issues.

11  
12 We are particularly interested in exploring the  
13 supported accommodation needs of people living with mental  
14 illness who have experienced homelessness or unstable  
15 housing, that is, housing that is accompanied by care,  
16 treatment and support for an individual with mental illness  
17 to support them to live a contributing life.

18  
19 We're considering a wide range of approaches to such  
20 supported accommodation within Victoria, around Australia  
21 and internationally, including those funded by the National  
22 Disability Insurance Scheme.

23  
24 In addition, we're interested in opportunities to  
25 address homelessness in young people experiencing mental  
26 illness. The Commission is aware of the potential lifelong  
27 impacts of mental illness and homelessness at a young age  
28 and of the evidence of the significant cost of youth  
29 homelessness in Australia.

30  
31 We are interested to understand opportunities for  
32 early intervention for young people with mental illness who  
33 are homeless that includes housing support.

34  
35 To quote an individual that attended our community  
36 consultation in Box Hill, "The one-size-fits-all model  
37 doesn't work", and I believe this remains particularly  
38 pertinent for any reform that we are to pursue.

39  
40 It is clear that across your statements there are  
41 broad areas of consensus, including the insufficient supply  
42 of social housing stock in Victoria, unmet demand for  
43 supported accommodation options for people with mental  
44 illness, and opportunities to improve and better leverage  
45 the National Disability Insurance Scheme specialist  
46 disability accommodation.

1 Today's discussion will seek to explore reform  
2 directions proposed in your witness statements. This will  
3 support us as a Commission to better understand our windows  
4 of opportunity to drive meaningful reform and change in  
5 this area.

6  
7 I would like to emphasise that today's deliberation is  
8 just one way that the Commission will obtain information on  
9 this issue.

10  
11 We remain committed to placing the views and  
12 experiences of people with lived experience at the centre  
13 of all of our inquiries. Insights and recommendations will  
14 continue to be sought from consumers, carers and families  
15 on this issue, as well as representatives from the mental  
16 health and housing sectors.

17  
18 Finally, before I hand over to Counsel Assisting,  
19 Fiona Batten, who will facilitate today's discussion, I  
20 would like to once again thank you for your time in  
21 assisting the Commission with our inquiry. We look forward  
22 to a robust and insightful discussion on a difficult but  
23 very important topic.

24  
25 MS BATTEN: Thank you, Chair. I will first introduce our  
26 three panel members for today's discussion and then I will  
27 outline the main areas proposed to be discussed. This is  
28 in no particular order.

29  
30 Dr Sarah Pollock is the Executive Director in research  
31 and advocacy at Mind Australia. In that role Dr Pollock  
32 advocates for social conditions in which people impacted by  
33 serious and complex mental health issues will have more  
34 equitable opportunities and a better quality of life.

35  
36 Over the last two years Mind Australia, together with  
37 the Australian Housing and Urban Research Institute, where  
38 Dr Fotheringham is from, has conducted a national research  
39 project called Trajectories. That project explores the  
40 interplay between mental health and housing pathways.

41  
42 Ms Cathy Humphrey is the Chief Executive Officer of  
43 Sacred Heart Mission and the Chairperson of the Council of  
44 Homeless Persons. Ms Humphrey has been working in  
45 government and not-for-profit organisations in areas  
46 specifically focused on people who are homeless since 1996.

47

1 Sacred Heart Mission delivers the Journey to Social  
2 Inclusion program, amongst other programs, and that program  
3 supports people to exit long-term homelessness.  
4

5 Finally, Dr Michael Fotheringham is the Executive  
6 Director of the Australian Housing and Urban Research  
7 Institute (AHURI). Dr Fotheringham is a research and  
8 policy development specialist with experience in housing  
9 and homelessness, public health and urban and community  
10 services planning.  
11

12 As I mentioned, AHURI was the partner with Mind  
13 Australia to conduct the Trajectories research.  
14

15 As the Chair mentioned, each panel member has provided  
16 the Royal Commission with a witness statement and they will  
17 be uploaded onto the Commission's website in due course.  
18 We are grateful for the considerable time and energy each  
19 witness has put into their statement and this panel  
20 process, particularly with the additional challenges of  
21 COVID-19.  
22

23 As the Chair also highlighted, there is broad  
24 agreement amongst the panel members on key issues relating  
25 to homelessness and mental health, and in particular the  
26 lack of secure appropriate affordable housing.  
27

28 But to assist the Commission consider the needs of  
29 people with mental illness, the panel discussion will focus  
30 on six areas. First, the nature of support people with  
31 mental illness need in different housing contexts; second,  
32 which group should be prioritised for additional support;  
33 third, the options for enabling consumer choice and  
34 control; fourth, increasing access to accommodation support  
35 through NDIS; fifth, considering innovative models for  
36 increasing the volume of housing stock and maintaining  
37 tenancies; and finally, examining the workforce  
38 capabilities that are needed.  
39

40 I will now turn to ask our panel members questions and  
41 the first topic is the nature of support for people with  
42 mental illness need in the context of housing.  
43

44 The first question seeks to explore the nature of  
45 support needed in four housing contexts. I will outline  
46 the question in full and then ask Dr Pollock to respond  
47 first.

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Dr Pollock, for people with severe and complex mental illness, what is the nature of support needed for people, first, who generally manage their tenancy well but who can become unwell; second, who need a medium term response that combines housing and supports; third, who need long-term specialised accommodation support; and fourth, who are chronically homeless? Dr Pollock, could you respond to that?

DR POLLOCK: Thank you, yes. In starting, I thought about this question, I think in fact the types of supports that are needed across those four groups are actually the same supports, but I think what there is, is the intensity and duration and the balance of the mix of the types of supports, and particularly the supports across clinical psychosocial and tenancy support.

I think there's also variation in the extent to which people need formal funded support coordination or system navigation, and the difference between the extent to which those supports need to be delivered assertively.

So, in general the supports that are needed are the supports you've noted, so first of all access to secure housing in a meaningful location. People need financial security as well. They need support to manage their tenancy, they need connection to a trusted worker somewhere, someone who they can believe and who they feel believes them and can help them navigate the system.

Help to manage the symptoms of distress and illness, but also help beyond that, so the sort of practical and emotional support that they can get through psychosocial services, help to deal with trauma and early intervention when things go wrong.

In relation to the specific groups, I would say that the people who are in a tenancy but need help when they go wrong, I think the really important thing there is that there's early identification that things are going wrong and an ability of services to - and a clear escalation pathway and services that then can flex up to support that person through their period of illness. I wouldn't expect that those people would need care coordination, but they might.

1           During a period of illness they need help with  
2 practical matters that are related to their tenancy, like  
3 paying bills and keeping the house clean, and they need  
4 someone to help them to possibly liaise with the tenancy  
5 manager or certainly to help them liaise with the tenancy  
6 manager.

7  
8           They need ramped up access to clinical support, and  
9 then, especially if there's a period of hospitalisation,  
10 they need ongoing support after that.

11  
12           I think for the second group, again, the housing  
13 tenure is the sort of precursor, and I think they need  
14 similar supports to the first group, but they need them  
15 probably at a higher intensity and for longer.

16  
17           I think we can assume that people in the second group,  
18 the people who need the medium term supports, have less  
19 stable mental health, so it's really important that  
20 clinical support can be there for them over a duration of  
21 time, flexing up and down as they need it.

22  
23           I think also one of the very important things for this  
24 group is helping them build community connections and  
25 supports in their community so that they're not only  
26 reliant on formal support services.

27  
28           I also think that there needs to be some consideration  
29 given to support to get them into education and employment  
30 in the long-term.

31  
32           And I think that, as the support period comes to an  
33 end, if they still need support, then they should  
34 automatically be NDIS eligible. So, if after a period of  
35 say 5 years you still need pretty much regular support,  
36 then that indicates to me that that's an NDIS need.

37  
38           The third group I think is the NDIS cohort, people who  
39 need long-term supportive accommodation, so the full range  
40 of supports to help them live independently; quick, rapid  
41 access to clinical support when they need it, help to build  
42 relationships with primary health providers. And I think  
43 for this group too, support to access education and  
44 possibly employment, whether that's voluntary or paid.

45  
46           I think for the fourth group, the real focus there has  
47 to be on understanding the underlying causes of the chronic



1 homelessness, not necessarily what drove them into  
2 homelessness in the first place, but what has contributed  
3 to the chronic nature of their homelessness and then  
4 support to deal with that, and I would suggest that that's  
5 likely to be support to help them deal with underlying  
6 trauma and quite possibly AOD support, as well as the full  
7 range of supports that I've mentioned for the previous  
8 groups.  
9

10 MS BATTEN: Thank you, Dr Pollock. Ms Humphrey, could you  
11 outline to the Commission the nature of the support that  
12 you think people with mental illness need, and just to  
13 clarify which cohort you're talking about, thank you.  
14

15 MS HUMPHREY: You can hear me?  
16

17 MS BATTEN: Yes, thank you.  
18

19 MS HUMPHREY: That's better. So, if we can talk to the  
20 first group of those who have become unwell. I use the  
21 term "sustaining tenancy support" and that does capture a  
22 whole lot of kind of ongoing enduring support that can flex  
23 up and down as needed, and it's about keeping people  
24 housed.  
25

26 It's a practice that's probably very underdeveloped by  
27 the sector because we tend to have a set and forget  
28 mentality of getting someone housed and our job is done and  
29 our belief is that it's actually not done; that's when the  
30 hard work starts about keeping people housed, so that  
31 practice development around sustaining tenancy support is  
32 really critical.  
33

34 Also is early identification and prevention of risk,  
35 and that's that risk of tenancy breakdown, and I think  
36 that's - the sustaining tenancies' role should pick that up  
37 early and avoid people's housing breaking down.  
38

39 Alongside that is self-management, so that's the  
40 development of kind of the personal social, capital to keep  
41 well and manage a crisis. In my statement I talk about a  
42 GP being really central to that.  
43

44 Alongside that is re-connection with family and  
45 friends, so building that social capital of others who have  
46 a care or concern for someone's life and what's happening  
47 in their world and with their health, so that development

1 of self-management strategies is really critical.

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1 including service navigation through very complex systems.  
2 We need to help people develop the independent living  
3 skills of managing a home because often they've not had to  
4 do that, whether that's paying bills, cleaning, whether  
5 that's establishing a tenancy, all those things that you  
6 and I can take for granted are really important.

7  
8 Then there's that coaching to self-management, so what  
9 does that look like in managing a crisis or managing a  
10 conflict, or recognising the signs of when I'm becoming  
11 unwell is really critical.

12  
13 Then those social inclusion activities that keep  
14 people connected to community and to that personal social  
15 capital that keeps them well.

16  
17 Trauma-informed care is really important because with  
18 this group there's often been an associated traumatic event  
19 that's led to their homelessness, but also the trauma of  
20 experiencing homelessness, so it's really essential that  
21 trauma-informed care is fundamental to the nature of the  
22 needs that's provided.

23  
24 Outreach assertive treatment is really important. And  
25 I kind of talk about the duration being something like a 2  
26 to 5 year that allows that kind of intensity, flexibility  
27 and responsiveness, because once people are housed that's  
28 when the real work starts. I'll stop there.

29  
30 MS BATTEN: Thank you, Cathy. Dr Fotheringham, we've had  
31 a very comprehensive outline of services, is there any  
32 other support that you would add that hasn't been covered?

33  
34 DR FOTHERINGHAM: I'm grateful to my fellow panellists for  
35 really answering the question for me, but I guess just to  
36 provide a little bit of complementary perspective: I think  
37 it's worth just stepping back and thinking about tenure in  
38 this. So, from a housing perspective, you know, mental  
39 health problems occur for people in all types of tenure,  
40 that includes homeowners as well as those in private  
41 rental, the social housing system whether it's community  
42 housing or public housing, and those experiencing or at  
43 risk of homelessness, and there are different supports  
44 needed for each of those tenure groups, if you like.

45  
46 So, for homeowners that support often comes through  
47 the medical system, but in terms of the housing impact can

1 be around loss of income which can affect mortgage  
2 payments, so that's where the banking system tends to be  
3 needed to support, mortgage holidays and various other  
4 mechanisms, which have waxed and waned over the years, but  
5 I think in our current COVID pandemic we're seeing a new  
6 wave of accommodating behaviour by the banking system.

7  
8 For private rental, there's probably less support  
9 systems around; there are some, but there is not as much  
10 tenure support for people in the private rental system.  
11 Community housing and public housing, the social housing  
12 system is where that's perhaps best shown.

13  
14 The housing first principle, which I know I think all  
15 three witness statements address in different ways, is an  
16 important principle; that people need to be housed to be  
17 able to progress their wider complex needs. You can't  
18 address people's complex needs while their housing is  
19 insecure and unsafe, and so I'll probably stop there.

20  
21 MS BATTEN: Thank you. The next question is directed to  
22 the support needed for youth and young people.

23  
24 It has been suggested to the Commission that the  
25 characteristics of effective housing and housing support  
26 for young people with mental illness are similar to those  
27 needed for adults, except there is a greater emphasis on  
28 family-based housing and support that is needed.

29  
30 The question is, do you agree with that position, and  
31 is a different approach needed in relation to young people?  
32 Dr Pollock, can I turn to you first.

33  
34 DR POLLOCK: Sure. So, I agree with the position to the  
35 extent that young people need housing, they need support,  
36 they need connection to communities, they need connection  
37 to meaningful activity, and for young people I think  
38 particularly connection to education, training and  
39 employment. But I think that there needs to be sufficient  
40 recognition and response to the developmental stage that  
41 young people - you know, that they're young people, they're  
42 not adults.

43  
44 I think too, the age that a young person ticks over  
45 into being an adult in service systems tends to get set in  
46 an arbitrary way, you know, we have to pick an age. But I  
47 think for young people who are trying to establish a life

1 at the same time as coming to terms with potentially having  
2 a significant mental illness, when that tipping point of  
3 young person into adult occurs will depend on when things  
4 first started to go wrong for them.  
5

6 So, if you're a young person whose life started to go  
7 off the rails when you're in primary school or early  
8 secondary school, by the time you reach your late teens or  
9 early 20s your life is likely to be in a pretty - you know,  
10 the risk is that, without appropriate supports, your life  
11 will be in a pretty parlous state and you will have missed  
12 out an awful lot of the development that your peers will  
13 have had.  
14

15 If, on the other hand, you first become ill in your  
16 late teens or early 20s, especially in your early 20s, if  
17 you've got some reasonable education under your belt the  
18 point at which you're starting from is very different and  
19 consequently, the sorts of supports you need are very  
20 different.  
21

22 So, I guess what I'm saying is, I think we need  
23 possibly to allow that notion of being a young person  
24 certainly, to extend into the mid-20s, and possibly even up  
25 to 30 for some young people because of their early - or  
26 their adolescence being disrupted.  
27

28 I also agree that attention to the family situation is  
29 a good idea, but I think it needs to be undertaken with a  
30 prevention framework. If we wait to do family focused work  
31 at the point when the young person is already in trouble  
32 and homelessness it's a very different kind of work from  
33 the family focus work that you might do when the young  
34 person is at home and possibly exhibiting the first signs  
35 of possible mental illness; often exhibits in behavioural  
36 issues at home or at school, and I think that's the point  
37 at which the family focus work needs to kick in.  
38

39 So, it's really important that, for young people, we  
40 actually have early identification of things going wrong to  
41 try and not get to the point where the young person is  
42 unwell and homelessness.  
43

44 So, youth appropriate housing needs to take account of  
45 the young person's relationship with their family, and that  
46 for some young people it's too difficult to reconnect with  
47 family at that point, at the point at which you're trying

1 to actually put some housing together for them; that may  
2 occur in the passage of time, but it may not be appropriate  
3 in the first place, so I think it's a sensitivity around  
4 when a family focus approach is appropriate and when it  
5 isn't.

6

7 Do you want me to talk as well about what I think  
8 about the approach that is needed for young people?

9

10 MS BATTEN: Yes, if you can briefly, I'm going to move you  
11 all along, but I will let you say this.

12

13 DR POLLOCK: Alright, I'll go as quickly as I can. The  
14 evidence suggests, and we put this evidence in our  
15 Trajectories research report, the evidence suggests that  
16 young people tend to be better in congregate care than  
17 adults, and that in that case housing first models actually  
18 do need some adaptation for young people, and  
19 Dr Fotheringham may be able to talk to that more than I  
20 can.

21

22 I think the supports provided need to respond to the  
23 likelihood that the young person who's experienced trauma  
24 either prior to becoming homelessness or through their  
25 homelessness experience, I think it's likely that support  
26 will need to deal with the issue of substance use, quite  
27 often as a form of self-medication or self-management of  
28 their mental distress.

29

30 Quite often young people have been involved in the  
31 criminal justice system, so sort of helping them sort out  
32 any outlying criminal justice issues, and then helping them  
33 to build - so kind of sorting out the worst of the mess or  
34 the difficulties, but in one sense helping them to build  
35 connections in a community that will sustain them and  
36 support them.

37

38 I know with the young people that we've worked with in  
39 residential settings, when the periods of time, whether  
40 that's short residential like the step-up/step-downs for  
41 PARCs or the longer residential youth ready rehab models,  
42 young people are quite fearful when it comes to the end of  
43 their period in the residential support; they're fearful  
44 that they're going to go back to the same group of friends,  
45 the same set of circumstances that actually drove them into  
46 the difficulties that are the combination of mental  
47 distress and no housing in the first place, so building

1 those informal networks, those community connections that  
2 are sustaining and nourishing is really, really important.  
3

4 I think young people also need at least assessment of  
5 the extent to which they need to develop skills for daily  
6 living; the sorts of skills that, you know, my kids  
7 developed at home, living at home with me for stuff like  
8 managing a house, budgeting shopping, cooking, taking care  
9 of yourself, taking care of a house and doing that with  
10 other people who might be living with you in that house.  
11

12 I think too young people need care coordination; it's  
13 too much to ask them to sort out all the different parts of  
14 their life where they will require help from different  
15 service systems without having some sort of formal  
16 coordination and formal service system navigation support.  
17

18 MS BATTEN: Thank you, Dr Pollock. Dr Fotheringham, I  
19 might turn to you next, could you tell us about the nature  
20 of supports that you think young people need.  
21

22 DR FOTHERINGHAM: Happy to, and I'd like to endorse the  
23 comments that Dr Pollock has made, and perhaps just expand  
24 a little bit specifically on the approaches to housing  
25 support for young people.  
26

27 I think there's probably two forms of that that I  
28 would like to put forward to the Royal Commission and some  
29 Victorian examples that demonstrate how that can be done  
30 well.  
31

32 The first is, as Sarah alluded to, the congregate care  
33 model, sort of congregate care version of the housing first  
34 principle which we see in the Foyer model, which is an  
35 internationally recognised approach to the congregate  
36 housing for young people where there is wrap-around support  
37 provided, often with someone living within a complex to  
38 provide 24-hour support, and with some expectations that  
39 residents engage in education or employment in some way.  
40

41 It's a fairly well developed model and the Drill Hall  
42 in Melbourne run by Housing Choices is a really good  
43 example of that model. There's many others as well, it's  
44 been adapted in different ways, but as an approach takes  
45 the housing first principles and adapts them to a young  
46 people cohort.  
47

1           The other group that I think it's worth acknowledging  
2           is those who have come through out-of-home care systems,  
3           whether it's foster care or kinship care or other versions  
4           of that type, and one of the challenges we've seen across  
5           the country is transition from those care environments into  
6           the wider housing ecosystem and that transition from being  
7           supported in that way to graduating from it when you reach  
8           a certain age. Different states across the country have  
9           different ages at which young people graduate from those  
10          programs, and the general pattern appears to be that, the  
11          later that is the better. So, that ranges from 18, 21,  
12          25 years old, and the longer the support generally the  
13          better. But a transition program can be a really important  
14          way to help people move from that supported environment to  
15          one where they're perhaps more independent.

16  
17           The Springboard program in Victoria has been a good  
18          example of that sort of approach run by DHHS.

19  
20          MS BATTEN: Thank you, Dr Fotheringham. Ms Humphrey, do  
21          you agree with the proposition that the characteristics of  
22          effective housing and housing support for young people with  
23          mental illness is the same as what's needed for adults?

24  
25          MS HUMPHREY: Yes, I do, and not being an expert in terms  
26          of support services for young people, but I would just like  
27          to probably note that it is really important that we  
28          prevent the trajectory of young people into adult  
29          homelessness, and so, I think I'd really support the  
30          comments made by Michael and Sarah in that respect.

31  
32          MS BATTEN: Thank you. This leads to the next question:  
33          of people who have severe and complex mental illness and  
34          housing support needs, are there particular cohorts who  
35          have more challenging support needs?

36  
37          Ms Humphrey, I might stay with you and see, in your  
38          view are there particular cohorts who have more challenging  
39          support needs?

40  
41          MS HUMPHREY: Yeah, the group that we tend to see are  
42          single adults who have really been experiencing long-term  
43          cycles of chronic homelessness, often with untreated mental  
44          health issues and that's exacerbated by being in and out of  
45          homelessness. Because of the lack of continuity of care,  
46          the person's kind of engaging and disengaging with the  
47          service system. Also, crossing regional boundaries, so



1 that kind of continuity of care really gets lost overtime  
2 and it's almost like you're starting again with the person  
3 as they're crossing boundaries.  
4

5 On top of this is kind of that multilayered factors of  
6 the impact of trauma alongside problematic drug and alcohol  
7 use, and often a cognitive impairment and they're the kind  
8 of groups that we really see who are difficult to engage  
9 and difficult to sustain their engagement in support  
10 services.  
11

12 I'm talking I guess from the 18 years of experience at  
13 Sacred Heart Mission of seeing this cohort cycling round  
14 and round and round the homeless services in the mental  
15 health service system.  
16

17 MS BATTEN: Dr Pollock, are there particular cohorts in  
18 your experience who have more challenging needs?  
19

20 DR POLLOCK: In the Trajectories research we were able to  
21 identify some of the risk factors or factors that really  
22 amplify the sort of nexus of housing instability or  
23 homelessness and deteriorating mental health, and I think  
24 these factors are all the things that Ms Humphrey has just  
25 referred to.  
26

27 So, substance abuse, history of abuse and/or being a  
28 victim of violence; history in detention; history in state  
29 care, and I think, too, long-term financial hardship.  
30

31 We also know from the Trajectories research that  
32 serious injury or serious illness amplifies the effects of  
33 housing homelessness, mental health interface and family  
34 violence, or rather, family breakdown.  
35

36 I think, as Ms Humphrey said, it's the people who are  
37 difficult to engage and difficult to keep in services, and  
38 they are often people whose behaviours are scary; they're  
39 scary for the people who work with them, they're scary for  
40 the public, and they're scary often for the individual  
41 themselves.  
42

43 I think that issue of chronicity, the longer the  
44 problems have gone on, the harder it is to engage and the  
45 harder it is to address and remediate the issues.  
46

47 I think then there's the issue of impaired cognition,

1 whether it's from an ABI or from an undiagnosed  
2 intellectual disability, or developmental delay, or simply  
3 the impacts of having led a really tough life for a long  
4 time with a serious mental health issue

5

6 MS BATTEN: Thank you. Dr Fotheringham, in your  
7 experience of people with severe and complex mental illness  
8 and housing support needs, are there particular cohorts who  
9 have more challenging support needs?

10

11 DR FOTHERINGHAM: This was a question that I was troubled  
12 by in initially looking at it, because I think I  
13 interpreted it as a question about diagnostic categories,  
14 you know, are there particular diagnoses that should be  
15 prioritised over others, and that was an idea that I found  
16 quite risky, in that, it could impact on the diagnoses  
17 given. If a person presents with a mental illness and is  
18 known to be at risk of homelessness or homeless, that their  
19 diagnosis might be impacted by that situation which could  
20 then compromise their care: I think that's a high risk with  
21 a sort of diagnostic approach.

22

23 What I do think is important, and it's a similar  
24 concept to what Dr Pollock has talked about, is their  
25 experience of homelessness or risk of homelessness, of  
26 trauma that I think concerns me most. I think what we know  
27 about homelessness risk, is the biggest predictor of  
28 becoming homeless is having been previously homeless. So,  
29 if we can address people whose housing is most vulnerable,  
30 that's the priority from my perspective.

31

32 MS BATTEN: I will come back to that priority question,  
33 but before we get there I would like to ask about the  
34 support needs for people who are living with a carer.

35

36 We've touched on this briefly with family focused  
37 work. But, Dr Pollock, if I can ask you first, where a  
38 person with mental illness is living with a carer, what  
39 support can help both the person and the carer to maintain  
40 that living arrangement, assuming it's an appropriate  
41 living arrangement?

42

43 DR POLLOCK: And I think that's a really important  
44 clarification, because I actually think it's important to  
45 challenge this assumption that everyone who lives with a  
46 carer, especially where they're living - with mainly a  
47 family member, that they as the individual or the family,

1 either party or both parties want that.

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1 opportunity to go into a step down before they go straight  
2 home.

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4 I think carers absolutely need respite and I think,  
5 with the introduction of the NDIS and the rollover of the  
6 Mental Health Carer Support Respite Program into the NDIS,  
7 it's actually quite fraught for carers to make sure that  
8 the individual gets the sort of support in their package  
9 that is the carer respite, and I think it's too soon to  
10 know whether the integrated carer support system will  
11 provide mental health carers with the access to respite  
12 that they need. I think that that is something that needs  
13 to be monitored by the State Government to see whether  
14 there is actually a state responsibility in there to  
15 supplement the respite arrangements that are available  
16 through those two Federal schemes.

17  
18 I think carers, certainly carers who have got somebody  
19 living at home, they need support, they need carer support  
20 too. Again, will the ICSS deliver that? I think it's a  
21 situation that needs to be monitored and we need to make  
22 sure that carers are supported to manage their own mental  
23 health and their own physical health.

24  
25 The other thing that Mind has a particular interest in  
26 is carers' access to employment and their support, their  
27 support to access employment in the first place and stay in  
28 employment. So, if you're a carer and you've got somebody  
29 living at home with a - an adult with a complex mental  
30 illness, it's really important that if you're employed  
31 you've got an employer who actually understands that you  
32 may need to really quickly and suddenly and unpredictably  
33 take some time off.

34  
35 So I think there needs to be some consideration of the  
36 sorts of programs that might help carers access and stay in  
37 work given the importance of financial security, and also,  
38 given the importance to carers of having an identity that  
39 isn't solely around being somebody's carer.

40  
41 There's a couple of programs in New South Wales that I  
42 think are very good in this space: the Care2Work, which is  
43 a Recovery College program that's specifically for carers  
44 to help them with skill matching, goal setting and resumé  
45 development. There's a Carer to Career program which is  
46 run through New South Wales TAFE, and there's a Carers +  
47 Employer program, which is actually aimed at assisting

1 employers develop flexible workplace practices to support  
2 carers and actually provide accreditation.

3  
4 So I note that those programs are not mental health  
5 carer-specific, but certainly I think they're of value to  
6 carers.

7  
8 MS BATTEN: Thank you. Ms Humphrey, can I turn to you  
9 next. In your experience, what kind of support would  
10 assist a person with mental illness and their carer  
11 maintain that living relationship?

12  
13 MS HUMPHREY: I think in addition to what Sarah has said I  
14 think that engagement of the carer in a co-care plan is  
15 really important, so with consent; so, both the carer and  
16 the person with the mental illness are supported to create  
17 a, whether it's a co-plan or a living plan, where there's  
18 agreement about how they work together to sustain that care  
19 arrangement.

20  
21 I think in addition to that is probably access to kind  
22 of brokerage and information and education is also  
23 fundamental for the carer.

24  
25 MS BATTEN: Okay, thank you. Dr Fotheringham, is there  
26 anything you would like to add on what can support carers  
27 and people with mental illness living with carers?

28  
29 DR FOTHERINGHAM: No, I would support and endorse the  
30 comments of the other two members of the panel but probably  
31 have nothing additional.

32  
33 MS BATTEN: Thank you. The second topic that I wish to  
34 address is the issue of prioritising which we've touched on  
35 briefly and I would like to ask you all directly.

36  
37 In the context of this Royal Commission into  
38 Victoria's mental health system, and considering the  
39 reality of rationed resources, of Victorians experiencing  
40 mental illness and homelessness or housing insecurity,  
41 which group would you prioritise for additional support?  
42 Ms Humphrey, can I ask you first, who would you prioritise?

43  
44 MS HUMPHREY: Look, I'd use a number of indicators to kind  
45 of direct me to the answer that I'll give you.

46  
47 One is around the group that's having the most impact

1 on the service system in terms of costs and service usage.  
2 A kind of theory is that, if you can meet the needs of this  
3 group, then you can free up the service system to meet  
4 others' needs. This is really an approach that we took to  
5 the Journey to Social Inclusion program which works with  
6 people who are experiencing chronic homelessness who a high  
7 portion of them have diagnosed mental illness but also  
8 mental health challenges.

9  
10 I think the other interesting thing is also the lives  
11 lost. We've seen through now two cohorts going through the  
12 Journey to Social Inclusion program, that lives lost to  
13 suicide and unmanaged mental health is quite significant.  
14 For me it points to that direction of, that adults who are  
15 experiencing long-term chronic homelessness who really have  
16 untreated mental health exacerbated by their homelessness  
17 experience.

18  
19 Equally, I'd also say we need to stop the trajectory  
20 of young people into adult homelessness alongside that.

21  
22 MS BATTEN: Thank you. Dr Pollock, can I turn to you  
23 next. Which group would you prioritise?

24  
25 DR POLLOCK: I think this is really difficult because,  
26 like my two colleagues, it depends on how you want to  
27 understand priority.

28  
29 I think, if we look at the greatest immediate need,  
30 people who are chronically homeless. If we look at the  
31 people who are at greatest risk of becoming the people of  
32 greatest need, it's the people in tenancies who become  
33 unwell without support and, I would add, I think that they  
34 are relatively cheap to support too. You know, if you get  
35 in quickly and get in with sufficient intensity, you can  
36 actually avert longer and costlier and potentially less  
37 efficient or less effective supports.

38  
39 The other group who are at greatest risk if their  
40 support needs are left unattended are those people in the  
41 medium term intensive support. Again, they're your next  
42 chronically homelessness group in the wings.

43  
44 I think, if we take an investment lens, then it's  
45 young people. Invest sufficiently and invest early for the  
46 greatest chance for those young people to lead contributing  
47 and meaningful lives.

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I think, as I said before, I think those people in tenancies also give good return on investment. So, you know, people who things are going along, go along most of the time they go along well; when they don't go well, they don't go well quite quickly; get the supports in, because quite often it's intensive but it's for a temporary period of time and, you know, people have a good return to being able to make a contribution.

Having said all that, I just - I feel really uncomfortable about ignoring those people who are less visible because they're sitting at home with mum and dad - whether mum and dad want that or not, whether they want that or not - or they're in an SRS, or they're in a boarding house or they're in a rooming house, so in those forms of sort of privatised, loosely regulated and minorly supported forms of accommodation, it's easy to ignore them because their needs are - at a very minimal level their needs are being met but they're not leading very contributing lives.

So, I find this question difficult and slightly uncomfortable because I think there are very good arguments for the needs of all of those people for different reasons.

MS BATTEN: Thank you for addressing it. Dr Fotheringham, who would you prioritise given the focus of the Mental Health Royal Commission and the limited resources?

DR FOTHERINGHAM: I guess I should apologise for jumping the gun and answering this question while addressing the previous question.

MS BATTEN: No, no, not at all, they're linked, you're ahead of us.

DR FOTHERINGHAM: But, yes, there's a flow to the discussion there that I think is important.

As I said earlier, I think a diagnostic lens on that is a potentially very risky one, I do think people's history and trajectory of housing and homelessness and related trauma, or housing insecurity to put it another way, is a really significant dimension to this.

You know, for young people who experience homelessness

1 in their childhood their future pathway in terms of  
2 housing, their housing careers, can be incredibly damaged  
3 and the interaction with that with mental health, I think,  
4 is something we're only just starting to understand but  
5 it's very significant.

6  
7 So for me, it's really about understanding people who  
8 are most at risk of homelessness and intervening early, as  
9 early as possible.

10  
11 MS BATTEN: Thank you. I'll move now to the third topic  
12 which is options for enabling consumer choice and control.

13  
14 I understand the difficulties with the lack of housing  
15 staff, but I still would like to ask, and I'll direct this  
16 to you first, Dr Pollock, what are the options for enabling  
17 consumers choice of housing, including the location of the  
18 housing and proximity to connections that are meaningful to  
19 the person?

20  
21 DR POLLOCK: I think, you know, you've pointed out the  
22 limitations: it's limitations of supply, it's limitations  
23 of diversity, of types of housing and it's limitations of  
24 where that supply actually is. People are also limited by  
25 having often very, very restricted financial resources, and  
26 limited choice over the supports they get and how those  
27 supports are delivered to them, and all of those things  
28 contribute to further limiting people's choices around  
29 housing.

30  
31 In the Trajectories research, in the community  
32 interviews that we did, people talked a lot about having a  
33 lack of control, and they talked about lacking control in  
34 the process of applying for housing. Some of that was the  
35 enormous sort of delays in formal processes around  
36 accessing social housing, particularly public housing;  
37 inefficiencies in the process, errors made, people's files  
38 being lost.

39  
40 And then basically having to talk to tenancy  
41 administrators and wait list administrators who were rude  
42 and unhelpful and lacking in understanding of people's  
43 situations, and all of those contributed to people feeling  
44 like they had no control over the process of trying to get  
45 a house, that they were just a number, that they as a human  
46 being weren't important and, you know, the very worst, that  
47 they were actually some sort of burden on a system that



1 they had believed was there to help them.

2

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4 People also talked about this same lack of control and  
5 lack of choice once they were housed over the things they  
6 needed to do to maintain their housing, maintain their  
7 tenancy: so being forced into inspections at times that  
8 didn't suit them. A family member talked about being  
9 really, really hassled by the public housing tenancy  
10 manager to do an inspection at a time when - her sister who  
11 lived with her - at a time when her sister was really,  
12 really unwell, and for her, her priority was her sister's  
13 health and helping her sister as she kind of gets things  
14 back together, and yet she had this tenancy manager on her  
15 back who just would not let up on this issue of, we're  
16 going to do the inspection, we're going to do it now, and  
17 if you fail the inspection you'll lose your tenancy. Those  
18 things contributed to really feeling like you've got no  
19 control and no choice over how you manage your housing.

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MS BATTEN: Ms Humphrey, can I turn to you: what are the options for enabling consumers' choice of housing, location and proximity to meaningful connections?

MS HUMPHREY: I think one of the recent improvements in Victoria is the development of the Victorian Housing Register, so that's a combined wait list for both community and public housing, and they have moved to more of an online system that hopefully will cover off on some of those challenges that Sarah spoke to around, you know, efficiencies and losing applicants' details, et cetera, so that process of applying for housing should be now more streamlined, although there are challenges for a community that doesn't have the IT literacy and that requires a service system to enable that IT access.

I think one of the possibilities that could come out of the Victorian Housing Register is that an ability to release data in local areas in which there are vacancies. What that means as a support provider that's supporting someone through the application process, there's no point choosing a local area in which there is no vacancies and will be no vacancies for the next 10 years. But if there are areas of vacancy turnover, it can then give people some choice of communities within those limitations. So, I think, if that data can be made available in the application process, it might help people's pathway through the wait time to be somewhat accelerated than it currently is.

I think one of the things that's really important is for the service system, whether it's the homelessness service system or mental health service system, is to have good housing and support planning. It is really fundamental for the workforce in both those sectors to understand housing pathways and the options to navigate those service systems on behalf of their clients. So, whether that's the NDIS service system, whether that's a housing service system, whether that's a private service system, we really need skilled staff that can help navigate that application and getting housing is really important.

I think the other opportunity is around DHHS staff that manage public housing. I think skilling up that workforce so that they can do that sustaining tenancy practices is really fundamental. So, if we can stop that

1 kind of exchange between their tenancy support workers that  
2 contributes to possible breakdown of the tenancies in  
3 public housing, I think that would be a great result.

4  
5 MS BATTEN: Thank you. Dr Fotheringham, can I ask the  
6 question to you, what are the options for enabling  
7 consumers' choice of housing, location and connections?  
8

9 DR FOTHERINGHAM: Again, a tenure focus to this is  
10 probably worth considering, because the degree to which you  
11 have choice of your housing is greatly influenced by what  
12 tenure form you take. For a homeowner there's obviously a  
13 very significant amount of choice, with a price caveat; for  
14 private rental similar but a slightly more constrained  
15 market. But for social housing and community housing  
16 choice is a lovely concept but not a reality at the moment.  
17

18 You know, the opening remarks this morning spoke of an  
19 80,000 person waiting list in Victoria: that's not an  
20 environment in which choice really exists, and most public  
21 housing systems, or most waiting lists across the country,  
22 if you refuse a property that's offered to you, you don't  
23 get a lot of other choices. You might get one other offer  
24 and then you go to the bottom of the list is a typical  
25 outcome. So, the notion of choice there is an artifice  
26 that the current supply of affordable and social housing  
27 just doesn't allow for. It should.  
28

29 The principle is really important, we've seen that in  
30 NDIS, and we'll talk about that shortly I think, but the  
31 concept that people can have some say in the built form of  
32 the house they live in, which could be quite significant  
33 from a mental health perspective, as is the surrounding  
34 environment and their connection to community are really  
35 important dimensions of how people live, and I think that's  
36 something that's been really demonstrated in the last  
37 few months as people have spent far more time than they're  
38 used to perhaps in their homes, and the role of local  
39 community in shaping that environment is really  
40 significant, so that's a dimension of choice that perhaps  
41 is lacking in the system generally.  
42

43 MS BATTEN: Dr Pollock, I'll address the next question to  
44 you, and very conscious of what Dr Fotheringham has just  
45 said, so potentially looking more towards an ideal system.  
46 What are the options for increasing consumer and carer  
47 co-design of housing and housing support?

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DR POLLOCK: I think, the more we can build co-production capability into the mental health system, the better. I would say that, to do that, that requires actually building co-production capability into every single organisation that comprises the mental health system.

I think that at the moment we have a tendency to rely on advisory panels that are kind of slotted into the system at various points and advise Government decision making, and then we rely on NGOs doing their best around co-design and co-production, so we end up with sort of centralised mechanisms for co-production through advisory committees and then some grassroots, and patchy - some better than others - some grassroots co-designed services or developments.

And this is noted in the literature on co-production, that there's a real problem bringing together - getting co-production to actually have any impact outside of the immediate location in which people are co-producing something, and particularly forming links between where co-production happens at a grassroots level and where it happens centrally, which is why I think it's really important to actually build that capability into all of the organisations that comprise the service system and to understand that it takes some resourcing to do that.

Beyond that, I would say we probably don't have the evidence base that we need to actually understand what are the sorts of design principles that might apply to housing for people with complex mental illness. I note that there's some work going on at the moment - various bits of work, I know because we're involved in it - on thinking about the physical design of emergency departments.

In mental health research there's beginning to be recognition that actually we need to pay attention to the design of the built environment in which various kinds of mental health interactions take place; I think that applies to people's housing as well and I think it would be great to see some research, some participatory research go on that really looks at what constitutes good design for people with complex mental illness.

In the Trajectories interviews, one of our researchers actually, one of our lived experience, our peer researchers

1 actually is an architect by background, and when she looks  
2 at - it's fascinating, because when she looked at the  
3 interview transcript she said, ah, this is really  
4 interesting, there's all this stuff in here about design  
5 which I don't think we would have picked up on because we  
6 didn't come to it with this dual lens of lived experience  
7 and the eye of an architect. So we've done some work  
8 together, so the research team, we've done some work and  
9 we've looked at some of the things that came out very  
10 clearly in terms of the sort of lived experience way of  
11 knowing about the design principles: so natural light,  
12 sound proofing, lines of sight into and within the  
13 building, particularly placement of windows and doors so  
14 that people feel safe inside their house. So that, when  
15 you open your front door, you're not looking directly into  
16 somebody's living space, or you can see the shower from the  
17 front door, and in fact there's another unit dead opposite  
18 yours with a front door right in front of it so that, you  
19 know, when you have your door open - in Australia  
20 especially in the summer with your screen door open quite  
21 often for long periods of time you're visible when you're  
22 inside the house.

23  
24 So that question of aspect and physical relationship  
25 to other nearby dwellings. Own garden or own private  
26 external space, very, very important. I think safety and  
27 privacy are really important. Now, those are some of the  
28 things that have come out from the interviews we've done.  
29 I think, given the reality of increasing consumer and carer  
30 co-design in the construction of actual dwellings is really  
31 limited. I think investing in some research to understand  
32 trauma-informed design in particular, but also what makes  
33 sense for consumers and carers would be really good.

34  
35 MS BATTEN: Thank you. Ms Humphrey, can I turn to you  
36 next to ask about the options for increasing consumer and  
37 carer co-design.

38  
39 MS HUMPHREY: Look, I'd like to follow on I guess and say,  
40 where there is an opportunity within the build environment,  
41 so where Government is providing grants to build new  
42 facilities or new properties or new housing, I think that  
43 engagement of the lived experience in the co-design  
44 alongside the architectural eye is really fundamental.

45  
46 We've seen that in our new facility called Sacred  
47 Heart Community, and it's a prime example of a co-designed

1 building for people who are ageing early as a result of,  
2 you know, the lived experience of being in disadvantage and  
3 homelessness who also have a mental health issue.

4  
5 What we're able to do is co-design a facility with  
6 those residents alongside the architect consulting with  
7 them and providing them examples of other facilities.

8  
9 If we take in a very mainstream aged care service we  
10 wouldn't have met the needs of the community which looks  
11 very different to an older cohort who are often bed-bound,  
12 where we're dealing with a younger cohort whose life  
13 experience is vastly different to that of mainstream aged  
14 care.

15  
16 So, for us, I think it meant that we developed a  
17 facility that really meets the needs of a very specialised  
18 cohort, so I think those principles of the build  
19 environment of building in principles of co-design  
20 alongside the architectural eye is really critical.

21  
22 Then, if I think of the support needs, I really think  
23 that the basic building block of effective assessment and  
24 good individualised service planning is fundamental, and we  
25 need to make sure that that's consistently practised across  
26 the service system, whether that's housing, homelessness,  
27 mental health service system, because I can tell you it's  
28 not, and I think that's the problem of that co-design at  
29 the beginning of identifying need and with the individual  
30 identifying a plan that will meet their needs; there is  
31 some gaps across the service system.

32  
33 MS BATTEN: Thank you. Dr Fotheringham, noting your  
34 comments earlier, do you have anything to add on the  
35 options for increasing consumer and carer co-design?  
36

37 DR FOTHERINGHAM: Yes, I do. Yes, within that context I  
38 alluded to of a shortfall of social housing supply, I guess  
39 it's worth recognising that Victoria currently has the  
40 lowest market share across the country of social housing,  
41 so the proportion of the overall housing stock that is  
42 social and affordable housing in Victoria is lower in  
43 Victoria than it is in any other States and Territories.  
44

45 But there are some really positive signs with the  
46 Victorian Government's announcements over the last couple  
47 of years, and in fact the last couple of weeks, for social

1 housing development and some positive moves as well in  
2 rental reforms in the private rental system addressing the  
3 pets dimension that Sarah talked about earlier which has a  
4 really important housing focus as well as on mental  
5 illness.

6  
7 Some of the recent reforms or announcements look at a  
8 significant build of social housing, and the disability  
9 sector I think are engaging quite strongly with that and I  
10 think it's quite important that the mental health sector  
11 does too.

12  
13 A good example of what that can look like, I guess,  
14 comes across the border in New South Wales, the SAHF, the  
15 Social and Affordable Housing Fund, which last year went  
16 into its second round of large-scale long-term funding.  
17 It's an approach that involves partnerships between social  
18 housing providers, developers and various landholders,  
19 which often are faith groups, church groups that own  
20 significant land, but not necessarily.

21  
22 Public/private partnerships involved in the community  
23 sector to co-design and co-deliver precincts of mixed  
24 tenure development, so the Ivanhoe development in Sydney is  
25 probably the best known example of that, where a really  
26 significant housing development that was situated close to  
27 a train station or around a train station, so good access  
28 to public transport which is an important dimension to  
29 many, with some private housing within that, some  
30 affordable housing within that, and some social housing  
31 within that, in a mixed model, so it wasn't sort of  
32 segregated housing within those and separate entrances for  
33 social housing dwellers and so on but actually much more  
34 integrated and comprehensive within a sort of precinct  
35 development approach. That model is less cost intensive to  
36 Government because it involves partnerships with developers  
37 and community sector and provides really good outcomes.

38  
39 I guess the contrasting journey for Victoria in the  
40 last three or four or five years while that's been  
41 happening in New South Wales is public housing  
42 redevelopment has become highly politicised, where  
43 redevelopment of public housing sites that have needed to  
44 be redeveloped because they've ceased to be really  
45 habitable have been approached with that sort of  
46 partnership in mind and the politics of it has been  
47 difficult, significant opposition to the approach, where

1 the net number of public housing dwellings has increased  
2 and other social housing and affordable housing as well,  
3 with private housing within it, but it has had a difficult  
4 journey in this state so that's something we would hope to  
5 see stronger bilateral support for going forward.

6

7 MS BATTEN: I might ask one more question and then give  
8 you all a break. We'll turn to the fourth topic which is  
9 increasing access to accommodation support through NDIS.

10

11 The first question is, what are the requirements of  
12 the NDIS for people with mental illness seeking specialist  
13 disability accommodation or supported independent living?  
14 Dr Pollock, can I ask you that question first?

15

16 DR POLLOCK: Sure. I think, before I answer the question  
17 specifically, I think there's a problem with the  
18 conceptualisation of disability that the scheme currently  
19 relies on. I think it still relies on quite a diagnostic  
20 frame for understanding disability, i.e. there's got to be  
21 diagnosis that underlies people's functional impairment.

22

23 Getting into the NDIS does require for people with  
24 psychosocial disability, it does require them to prove a  
25 diagnosis and to prove permanence, or the likelihood of  
26 permanence of the diagnosis and of likely long-term or  
27 lifelong support need; rather than relying on evidence of  
28 significant and ongoing functional impairment and need for  
29 support around functional impairment. What this does is, I  
30 think, separates people with a so-called disability from  
31 people with debility.

32

33 So, I think the NDIS is particularly poor at  
34 responding to significant levels of debility that have  
35 often been poor. So, if we think about the various cohorts  
36 that Cathy Humphrey has described today, the people who  
37 have had multiple experiences, multiple systems fail them  
38 over a long period of time to the extent that they carry  
39 significant debility, there are problems for them getting  
40 into the NDIS because it doesn't recognise debility as a  
41 kind continuum within disability.

42

43 So, having said that - and I think it's a major  
44 problem for people who have got complex support needs -  
45 having said that, the general requirements are set out in  
46 s.24 of the Act and they relate to permanent impairment  
47 associated with substantially reduced functional capacity



1 to undertake one of a number of core activities, and where  
2 that impacts on capacity also limits a person's social and  
3 economic participation.  
4

5 The NDIA then identifies six criteria for having SIL  
6 in your package, but these I think are quite vague  
7 criteria, and I haven't got them in front of me I'm afraid  
8 but they're on the NDIA website, but they're very broad,  
9 they're things like goal setting, engagement and planning;  
10 that sort of thing.  
11

12 At Mind, we've developed our own process. We have a  
13 customer service centre, so people ring up and they say,  
14 you know, I'm interested in accessing the NDIS and we have  
15 developed a particular set of inclusion criteria for  
16 advising somebody to ask for SIL in their package, and we  
17 have about a 98 per cent success rate for people who ask  
18 for SIL and get it, so I think that indicates our inclusion  
19 criteria works quite well.  
20

21 A history of housing insecurity and/or homelessness  
22 and evidence to support that, a long-term reliance on  
23 clinical support, so that might be a period of time in a  
24 CCU, repeated use of PARCs or step-up/step-down, and  
25 multiple inpatient stays over a 24-month period. Again,  
26 ability to evidence that.  
27

28 Then the ability to provide evidence that shows how  
29 their mental illness impacts on their day-to-day living and  
30 on their social and economic participation. And, if people  
31 are able to do that, they are likely to get SIL in their  
32 packages.  
33

34 I think that the NDIA are going to tighten up their  
35 criteria around SIL, I think coming out of both TUNE and  
36 the recent joint standing committee look at SIL, I think  
37 these will get tightened up. But in reality what actually  
38 happens is - and this goes to Ms Humphrey's points about  
39 how vacancies are managed - in reality what happens is,  
40 people ring us and say, "I see you've got a vacancy in a  
41 SIL property. I've got somebody who would like that but  
42 they don't have SIL in their package." So, most of the  
43 time a support coordinator or a planner, or sometimes a  
44 family member, will identify that we have a SIL vacancy and  
45 that will kick off somebody then asking for a plan review  
46 and asking to get SIL into their package through the plan  
47 review. And at the moment there's quite a considerable

1 time lag of between three to six months for that plan  
2 review to happen and the person to get SIL in their  
3 package, so I think it's quite an inefficient process.

4  
5 In terms of SDA, even more difficult. SDA is really a  
6 specialist housing solution that I think has been  
7 predicated on the notion of physical disability where what  
8 you need is ramps and hoists and wide doorways and, you  
9 know, walls that don't fall apart if you bump your  
10 wheelchair into them. So, the criteria to get SDA in your  
11 package is associated with extreme functional impairment  
12 and very high support needs.

13  
14 At the present time I think there are around 468  
15 people with SDA approved in their plan, on the basis of  
16 primary psychosocial disability. But I guess that only  
17 around 300 people actually have SDA properties. I would  
18 say this notion of primary psychosocial disability often,  
19 to the extent that we know about this, those people who  
20 have SDA with primary psychosocial actually either have  
21 long-term histories of institutionalisation, so all of the  
22 sorts of developmental delay issues that you have if you've  
23 lived in an institution for 20 years, or my guess is they  
24 will have considerable cognitive impairment. Now, whether  
25 that's identified or not and included as part of their  
26 package, I don't know, but I suspect there's quite a bit of  
27 unrecognised or unassessed/non-assessed cognitive  
28 impairment. Really difficult to get SDA for psychosocial.

29  
30 MS BATTEN: Thank you, Dr Pollock. Ms Humphrey, can I  
31 turn to you, is there anything else that you can add on the  
32 requirements to access the SDA or the SIL for NDIS for  
33 people with psychosocial disability?

34  
35 MS HUMPHREY: I think following on from Sarah's comments,  
36 I really think it points to that workforce capability  
37 development that's required and the need for service  
38 navigators. I think it's a complex system and, in terms of  
39 NDIS, and then on top of that access to SDAs and SILs is  
40 quite complex as well.

41  
42 I am very interested to hear Mind's approach around  
43 their customer assessment process around SILs, and I think  
44 that sounds like a great example of something that should  
45 be replicated more broadly across the service system.

46  
47 MS BATTEN: Thank you. Dr Fotheringham, is there anything

1 you can add about the requirements for NDIS first accessing  
2 the SDA and SIL?

3

4 DR FOTHERINGHAM: Nothing of substance. I think  
5 Dr Pollock has answered the question very thoroughly and  
6 very well and I agree with all her comments. I think she  
7 can add to them.

8

9 MS BATTEN: I'll come back to you, Dr Pollock.

10

11 DR FOTHERINGHAM: So no, I'll sit aside.

12

13 DR POLLOCK: So, SDA and SIL are not the only housing  
14 supports available through the NDIS. Do you want me to say  
15 a little bit about the other supports because I think  
16 they're greatly under-utilised?

17

18 MS BATTEN: Yes, if you can say those briefly and then  
19 after the break I'll come back to each of you and ask what  
20 can be done by NDIA to better access all of these supports  
21 and then what the state can do to help people better access  
22 these supports. Thank you, Dr Pollock.

23

24 DR POLLOCK: So, there's two specific items in the NDIS  
25 price guide: the first is a capacity building item called  
26 Improved Living Arrangements, and that is really designed  
27 to help people with any activities that relate to their  
28 accommodation. So, that may be helping them to apply for a  
29 rental tenancy or undertaking tenancy obligations, but it's  
30 very specific around helping them to secure and maintain a  
31 tenancy.

32

33 The second one which I've actually only just found out  
34 about, and I think that fascinates me, it's only in the  
35 last couple of weeks because I've been digging around in  
36 the NDIS because of this panel, I discovered there's a  
37 thing called capital support for home modifications, which  
38 I guess I knew about, I knew about it in relation to  
39 physical disability, but potentially it's there to be  
40 applied to people with psychosocial disability; for  
41 instance, soundproofing.

42

43 So, sound disturbance, particularly at night, for a  
44 lot of people with a complex mental illness can be a  
45 significant stressor, and then lack of sleep can be one of  
46 the things that tips people from going along really, really  
47 well into being very, very unwell.

1  
2 Potentially the home mods, it's called capital  
3 improvements to a building, I am not aware that this has  
4 been used at all for the sorts of things that people with  
5 psychosocial disability might need modified in their  
6 building. I also think there may be a barrier for people  
7 living in social housing making certain kinds of home  
8 modifications.

9  
10 This has come up because I've got a friend who's  
11 actually in this position of wanting some soundproofing  
12 but, (a) not being able to get it through the NDIS, and  
13 (b) whether she can actually make the modifications to her  
14 property or not is another matter, but it's kind of opened  
15 up this whole kind of area and whole kind of question for  
16 me about what is an appropriate application of that home  
17 modification for people with psychosocial disability.

18  
19 MS BATTEN: Thank you very much. I will give everyone a  
20 break, so I'll give you all 10 minutes. I have five more  
21 questions for you and then I will hand over to the  
22 Commissioners after that. Thank you very much everyone.

23  
24 **SHORT ADJOURNMENT**

25  
26 MS BATTEN: Thank you everyone. As I mentioned before the  
27 break, I just have five more questions for you and then I  
28 will hand over to the Commissioners.

29  
30 We're still in the topic of trying to increase access  
31 to accommodation support through NDIS. Dr Pollock, you  
32 just very helpfully outlined the different sources of  
33 potential NDIS funding.

34  
35 My question, and I'll direct this first to you,  
36 Dr Pollock: how can the NDIA improve the ability of people  
37 with mental illness to access those supports?

38  
39 DR POLLOCK: I think that's a very good question. I think  
40 some of this actually goes back to the sort of original  
41 design of the NDIA and the NDIA's own understanding of what  
42 psychosocial disability actually kind of looks like and  
43 consequently what sorts of things support people with  
44 psychosocial disability, and particularly how - the role  
45 that housing plays in improving the lives and the outcomes  
46 of people with psychosocial disability. So, I think it's  
47 about the NDIA's own understanding of the intersection

1 between housing, mental health and mental illness and  
2 disability, and in the context of trying to achieve a  
3 contributing life.

4  
5 I think that, if the NDIA - so some of it, kind of  
6 speaks to the NDIA's own understanding of these things and  
7 their own workforce capability, particularly planners,  
8 particularly planners and LACs, but probably also people  
9 who make decisions that impact on what goes into people -  
10 you know, make eligibility related decisions and package  
11 size decisions.

12  
13 I think generally if the NDIA want to improve the  
14 ability of people with mental illness to access SDA and SIL  
15 and other housing supports, I think the NDIA needs to  
16 improve its own understanding of what those things look  
17 like and why they matter.

18  
19 I think more consideration needs to be given to the  
20 possibility of having congregate care, congregate models as  
21 one option. I know that, in the NGO sector, and amongst  
22 consumers, there's some opposition to anything congregate  
23 because it's seen as, you know, that's not how other people  
24 live. Well, actually it is. If I think about modern urban  
25 apartment living that's exactly what we're talking about.

26  
27 So, we're talking about high quality congregate  
28 models, where people have their own apartments and have  
29 access to their own private space, but they also have  
30 access to the 24/7 support that they might need. And I  
31 would say that probably up to a maximum of 15 people; once  
32 you get beyond 15 people then you move into some sort of  
33 different notion of congregate care. At the moment there  
34 are rules and regulations that prohibit that or certainly  
35 make it much more difficult.

36  
37 I think some of the NDIA workforce capability, and  
38 then looking at the NDIA's own rules and regulations to see  
39 where it presents options like congregate living, would  
40 certainly enable people to access more housing support.

41  
42 MS BATTEN: Thank you. Ms Humphrey, can I turn to you  
43 next. Are there things that you think the NDIA could do to  
44 help people with mental illness access better accommodation  
45 supports?

46  
47 MS HUMPHREY: I think the role of the local area

1 coordinator is something that should be examined, and the  
2 clarity about where housing risk is identified in the  
3 support plan, what is there in the role around considering  
4 SILs and SDAs within that context. I mean, I guess that's  
5 what I would add to what Sarah's already outlined.  
6

7 MS BATTEN: Thank you. Dr Fotheringham, is there anything  
8 that you would like to add on what NDIA can do?  
9

10 DR FOTHERINGHAM: I guess I want to make the remark that,  
11 you know, the NDIS has been a really rapid rollout of a  
12 very comprehensive and wide-ranging system reform, and that  
13 has led to a number of challenges around information  
14 dissemination, clear guidelines, and consistent  
15 understandings of the system across the country.  
16

17 And, as Dr Pollock mentioned, the understanding of  
18 that system of psychosocial issues is still developing,  
19 which means that determination of understandings of  
20 guidelines and protocols is a constantly evolving piece.  
21 It's not a static system at this point and not even close  
22 to it, so it's very early days for the whole system, and I  
23 think just as a communication exercise that's a really  
24 difficult challenge. So, if people who are working within  
25 the system are struggling to understand how the system  
26 works, how can consumers understand how the system works  
27 and know what to ask for?  
28

29 And that's a profound challenge still, and that's a  
30 challenge for physical disabilities as well. I mean, it's  
31 not as though that's all clear and completed.  
32

33 Sarah mentioned capital improvements and some of the  
34 work AHURI's done in terms of disability housing in  
35 relation to physical disability has shown that the capital  
36 improvements side or stream of funds is a really difficult  
37 one to access and a difficult one to use, so it's useful  
38 for mental illness, I think. It's certainly worth  
39 exploring and worth supporting, but by no means simple.  
40

41 I just wanted to, I guess, touch on Dr Pollock's  
42 comments around congregate housing and I think it's worth  
43 just making a distinction between two forms of that. She  
44 talked about apartment complex living and, you know, studio  
45 apartments and the like where one of the apartments is  
46 occupied by a carer of some form, versus some of the other  
47 congregate housing that's been used in the disability space

1 over the years which tends to be more like a sharehouse,  
2 where you have your own room, but it's shared kitchen,  
3 shared land facilities and so on, but you don't actually  
4 have a choice about who your housemates are, and that's  
5 quite a different scenario and probably a different set of  
6 outcomes, and I think the more we're moving towards that  
7 apartment complex version rather than the forced share  
8 house version, then I think that's a positive.

9  
10 MS BATTEN: Thank you. The last question related to NDIS  
11 is the role of the State Government, so the question  
12 specifically is, how could the State Government better  
13 support people with mental illness to access SDA and SIL  
14 and the other supports that have been mentioned funded by  
15 the NDIS?

16  
17 Ms Humphrey, I might turn to you first to see what you  
18 have to say about what the state can do.

19  
20 MS HUMPHREY: Look, I think there is a gap between  
21 connecting people into the NDIS in totality, whether that's  
22 then leading to SDA or SIL access, and I think that really  
23 points to the need to fund the systems advocacy and service  
24 navigation role. There's a real gap in the service system  
25 with, you know, now the loss of the PDRSS system in  
26 Victoria of kind of what we need to do prior to the NDIA in  
27 order to get someone into that service system. So, I think  
28 there's a kind of functional gap within the service system  
29 that the State Government needs to fill in the absence of  
30 the PDRSS program.

31  
32 MS BATTEN: Dr Pollock, can I turn to you next, what do  
33 you think the State Government could do to enable people to  
34 better access the supports under NDIS?

35  
36 DR POLLOCK: Look, I fully concur with what Cathy's just  
37 said about system navigation and care coordination. People  
38 need the support coordination within the NDIS to be  
39 sufficient; it's kind of underdone I think, in terms of  
40 actually helping. It's underdone in terms of how the  
41 role's conceptualised and how it plays out. I think anyone  
42 with complex needs, some State Government funded  
43 coordination and navigation would be really, really  
44 helpful.

45  
46 I think there's some workforce issues. Just  
47 upskilling the mental health workforce in the most general

1 sense around the role that housing plays in people's  
2 wellness and illness. Both the clinical programs that  
3 actually interface with the NDIS, so the EIPRS, the Early  
4 Intervention, Prevention and Recovery Support program,  
5 which is really an NDIS gateway, it's really important for  
6 the people, the NGOs and clinical partners who are  
7 providing that to have good housing capability.

8  
9 I think beyond having a housing aware mental health  
10 workforce that can then help people either access NDIS, or  
11 who are within the NDIS to actually access the housing  
12 supports that are available; I think that would be helpful.

13  
14 MS BATTEN: Dr Fotheringham, is there anything that you can  
15 add on what the state could do to support people to better  
16 access the NDIS?

17  
18 DR FOTHERINGHAM: My understanding is that New South Wales  
19 has done a bit of work and I believe this connects through  
20 to the social and affordable housing fund that I talked to  
21 earlier that has prioritised disability housing in some  
22 parts of the program.

23  
24 I guess it's also worth making the point that there is  
25 a supply issue here as well and it sort of echoes some of  
26 my earlier remarks about the social housing system and the  
27 size of the waiting list. The sense that there is  
28 sufficient SDA funds to meet those needs, you know, in a  
29 physical disability space: it's clearly not, it's a very  
30 small proportion that's met. So, again, we have a really  
31 significant gap between the size of the demand and the size  
32 of the available funds, the available supply. And I think  
33 that's the context that, as much as it is repetitive to  
34 keep reinforcing, it is a really important part of the  
35 context.

36  
37 MS BATTEN: Thank you. This leads on to where I'm going  
38 to direct my questions to you, Dr Fotheringham, about  
39 innovative models. You mentioned the SAHF fund before.  
40 Can I ask you this question and maybe if you need to return  
41 and expand on this on what your comments were in relation  
42 to the SAHF fund please do so.

43  
44 Are there innovative ways the State Government could  
45 increase the volume of appropriate affordable housing stock  
46 for people with mental illness?



1 DR FOTHERINGHAM: Thank you, yes. And look, I think SAHF  
2 is a really good example of that so I will perhaps draw on  
3 that example again. And again, a bit of context setting,  
4 it's worth recognising that housing policy in Australia is  
5 split across levels of Government. A lovely Federation  
6 means that the Federal Government has some responsibilities  
7 for housing policy, and the states and territories have  
8 other responsibilities, and for that matter so does Local  
9 Government, and that creates, I guess, a division or a less  
10 accountable sense because of that dispersion of  
11 responsibility.

12  
13 But the states clearly have a key role and a lead role  
14 in many respects, including the supply of social and  
15 affordable housing through the public housing system and  
16 support of the community housing system.

17  
18 There is, I think, a need for much greater emphasis on  
19 disability accommodation generally, physical and mental  
20 health included. I think the way in which the continuing  
21 evolution of a multi-provider system; I guess, going back  
22 many decades there was a public housing system and that was  
23 essentially the offering for affordable housing, it was  
24 largely targeted to key workers, and that's sort of the  
25 very early history of public housing in this country.

26  
27 But over recent decades that's shifted to become more  
28 of a multi-provider system where the state-owned and run  
29 public housing sits amongst a combination of community  
30 owned and operated social and affordable housing, and  
31 housing that is perhaps formerly owned by the state or  
32 still owned by the state but managed by the community  
33 sector. So, there's a complex system of suppliers there  
34 and it is entirely possible for the state to prioritise  
35 funding towards particular cohorts and, to my knowledge,  
36 mental health has not been amongst the cohorts of  
37 particular attention in that space, in Victoria's recent  
38 history, but certainly there is opportunity for that.

39  
40 That probably needs to be pragmatically built into  
41 other programs. So, recent announcements by the Victorian  
42 Government of significant building of social and public  
43 housing could be fine-tuned to have particular emphasis on  
44 mental health. That would be a really positive step.

45  
46 Programs like the SAHF fund which harness private  
47 sector engagement, community sector as well as Government

1 to effectively a multiplier effect through that  
2 partnership. Again, an emphasis on mental health within  
3 the design of those programs would be incredibly  
4 beneficial.

5  
6 MS BATTEN: You also mentioned stock transfer. Could you  
7 just explain how that works, the stock transfer arrangement  
8 works, and then also if I can ask you to maybe go into more  
9 detail with the SAHF fund with the Ivanhoe example, what  
10 the partnership arrangement was exactly and the roles of  
11 the different players.

12  
13 DR FOTHERINGHAM: Sure. So, stock transfer, there's two  
14 forms of stock transfer which is really the movement of  
15 housing stock from the public housing system, for the  
16 state-owned and run housing system, to the community  
17 sector. And that's done for a range of reasons but there  
18 are two key forms of it: one is title transfer where not  
19 just the management of the property but the ownership of  
20 the property is transferred to a community organisation,  
21 often through a tender process. And the other is  
22 management transfer, where the state retains ownership of  
23 the property and the land beneath it, but a community  
24 housing provider will take over the management of the  
25 property itself and of the tenancy within it.

26  
27 The motivations for that process are complex, there  
28 are a whole lot of sort of funding implications for that,  
29 and one of which is access to Commonwealth rent assistance,  
30 so tenants who need rent assistance because their income is  
31 not sufficient or adequate for the rental.

32  
33 That's not available to public housing tenants but it  
34 is available to community housing tenants, so that switch  
35 has an impact on the cost sharing between state and  
36 Commonwealth.

37  
38 But, more significantly perhaps, the transfer of  
39 management of stock to the community sector is believed to  
40 have better outcomes for the tenant. There is a perception  
41 that the caseloads that are typical of a community housing  
42 provider are lower than for a public housing tenancy  
43 manager.

44  
45 I've recently heard someone in Victoria say that as a  
46 public housing tenancy manager they had 300 tenants on  
47 their books as a tenancy manager and they moved to a role

1 in the community sector where they had 80 and that was  
2 considered a high load in that sector. So, you know, there  
3 are different approaches to tenancy management in those  
4 systems and different emphases.

5

6 And there is a bit of a prevailing assumption that the  
7 community sector provide better outcomes for tenants and  
8 for the management of the properties. Now, that's not  
9 necessarily evidence based but that is an assumption  
10 underlying that transfer.

11

12 In terms of the SAHF program and the Ivanhoe example  
13 in particular: well, I'm not privy to the contract,  
14 unfortunately, but what I can say is that, look, it  
15 involved a significant developer, one of the sort of names  
16 that you see all over the town, you know, on construction  
17 sites; major development. I'm not sure how many  
18 apartments, a couple of hundred I think overall, or at  
19 least a hundred, and a community housing provider,  
20 I believe it was Mission Australia in this particular  
21 example but there have been many involved; the bidding  
22 process for that fund was exhaustive. And use of  
23 Government land as well, so there was a complex arrangement  
24 involving Government assets and the private sector and  
25 community sector coming together in a really complex  
26 partnership.

27

28 There have been two rounds of that fund so far, really  
29 significant investment of funds in I believe the billions  
30 of dollars for long-term housing outcomes.

31

32 MS BATTEN: Thank you. Ms Humphrey, can I turn to you and  
33 ask you about innovative models, and particularly some of  
34 the work that Sacred Heart's been involved in.

35

36 MS HUMPHREY: I think there are opportunities for that  
37 private sector investment to be explored. We certainly  
38 began some conversations with private sector investors  
39 about their interest in developing accommodation options,  
40 but it is a piece of work that's underdeveloped.

41

42 I think the other area of opportunity, you know, there  
43 is the affordable housing social impact bond money sitting  
44 with - where Hesta has made available funds through  
45 superannuation to Social Ventures Australia which I don't  
46 think the uptake has been significant. So, I think there  
47 are those kind of options that ring in that kind of

1 investor environment into creating housing options, you  
2 know, alongside access to the NHFIC fund for community  
3 housing providers to get low cost debt.

4  
5 I think there's ways of kind of massaging the  
6 available mechanisms to create some opportunities, and I  
7 think, you know, really it's got to be led through  
8 community housing providers that want to provide  
9 particularly options for this cohort group.

10  
11 I think Michael's outlined a couple of examples of  
12 those. I couldn't add to that detail. From a support  
13 provider perspective I think, having payment by results  
14 contracts really drives a support provider to really focus  
15 on outcomes in a supported accommodation environment, so  
16 that alongside the capability of investing into housing,  
17 alongside support models that are outcomes-driven, I think  
18 get great results.

19  
20 MS BATTEN: Dr Pollock, can I direct this question to you,  
21 about innovation and opportunities to increase the housing  
22 stock.

23  
24 DR POLLOCK: You can direct me, but I actually don't have  
25 anything to add to what my colleagues have already said.

26  
27 MS BATTEN: Okay, thank you. Dr Fotheringham, I'll come  
28 back to you, would you like to add something else?

29  
30 DR FOTHERINGHAM: Dr Pollock and I are running a good tag  
31 team, I think.

32  
33 I would actually like to expand a little bit and thank  
34 you, Cathy, for mentioning NHFIC. The National Housing  
35 Finance Investment Corporation is a Commonwealth initiative  
36 that I think provides a really interesting angle on the  
37 question you're asking.

38  
39 It has several functions now, but one of its core  
40 functions is the bond aggregator which is a mechanism  
41 through which financiers, often superannuation funds or  
42 large-scale investors, can make contributions to social  
43 bonds that are backed by Government guarantee, you know,  
44 for a reasonable rate of return but with a social impact  
45 purpose to them, and those bonds are aggregated by NHFIC,  
46 collected by NHFIC, and then awarded to community housing  
47 providers through an incredibly detailed, effectively

1 tender process, bidding process, for development of  
2 affordable housing, of social housing. In its very short  
3 history that's already channelled billions of dollarsworth  
4 of money into the community housing sector, and that's  
5 starting to form direct relationships between the  
6 large-scale investors, the financiers and superannuation  
7 funds who historically have invested in social housing in  
8 the UK and US but not in Australia, and we're talking about  
9 Australian entities; is building connections between those  
10 financiers and the community housing sector which will  
11 start to build a life of their own and that's one of the  
12 knock-on effects of that system.

13  
14 Victoria has also announced a bond aggregation, but  
15 the uptake I think is probably less. The volume of funds  
16 available are smaller, the ambition is smaller, it's not a  
17 national scheme, but there would be an opportunity for the  
18 Victorian Government to re-tool that mechanism to focus  
19 specifically on areas of need, and so that could housing  
20 for mental health. Part of this is about the impact, the  
21 social impact that those investors can point to and that's  
22 significant for them in a range of ways.

23  
24 I would have thought that this is an area that has  
25 real potential for them. In terms of how bond aggregation  
26 works, there's a long history of AHURI research that has  
27 built this model and examined the international evidence  
28 over the years in coming together to do this that informed  
29 the development of NHFIC and I'm happy to share those  
30 (indistinct words).

31  
32 MS BATTEN: The next question is still on innovative  
33 models, and, Dr Fotheringham, I direct this to you first  
34 again. What could be done to better support people with  
35 mental illness to maintain private rental tenancies?

36  
37 You touched on this earlier, but what needs to be  
38 done? You mentioned that this was a cohort that's  
39 undersupported, but what supports or what can be done to  
40 maintain those tenancies?

41  
42 DR FOTHERINGHAM: Thank you. My understanding is, there  
43 are fairly limited programs, and I think even more limited  
44 awareness of programs that are available to support tenants  
45 in the private rental system through the sorts of  
46 challenges we're talking about today. Awareness of them  
47 would be a first step.

1  
2 Part of the complexity of the private rental system  
3 which is, and I should acknowledge, is the growing tenure  
4 form in this country. So, more people are renting and more  
5 people are renting for very long periods of time. I mean,  
6 the sort of more traditional sense of an Australian housing  
7 career was that you lived with your parents, then you moved  
8 out and rented for a year or two and then you bought your  
9 own place and settled down. That's shifted dramatically.

10  
11 There are very significant numbers of the population  
12 renting for 10 years or more, either in one place or  
13 sequentially, more often sequentially, and increasingly  
14 we're seeing people who are retiring while renting in the  
15 private system, and that's financially very challenging.

16  
17 There are also two ways in which people can be  
18 involved in rental in the private system. One is renting  
19 directly with a landlord, often the mum and dad investor, a  
20 small-scale investor with just a few properties often close  
21 to their own home, and the other is through a real estate  
22 agent, and the dynamics there are incredibly different, and  
23 I think this is probably an unappreciated aspect to this.

24  
25 One of the responses to the COVID pandemic and impacts  
26 on employment in this country, across the country we've  
27 seen state governments put forward models of negotiation  
28 between tenants and landlords, and well, that's not an even  
29 negotiation in that case, there is a power differential  
30 there automatically.

31  
32 But also, in many of those there is a third party with  
33 a different set of interests in the situation, so there's  
34 the outcome for the landlord, there's also the outcome for  
35 the real estate agent.

36  
37 Similarly, the information that can be made available  
38 to a tenant, a real estate agent actually might have better  
39 access to that information, be more aware of the programs  
40 that are around than an individual who's invested in a  
41 property as their nest egg that is then renting it out will  
42 probably not be aware of some of those programs, so just  
43 the awareness of them, let alone the scale of them and  
44 availability of them is a really significant area for  
45 improvement.

46  
47 MS BATTEN: Thank you. Ms Humphrey, can I turn to you

1 next. In your view, are there things that can be done to  
2 better support people with mental illness maintaining  
3 private tenancies?  
4

5 MS HUMPHREY: There's an example within the Victorian  
6 Homelessness Service System, a program called PRAP, which  
7 is Private Rental Access Program which has taken a focus on  
8 homelessness and family violence, and I think there's an  
9 opportunity to expand that program into responding to  
10 people with mental illness.  
11

12 So that works to both secure and sustain housing in  
13 the private rental market. There is a program called PRAP  
14 Plus that does a little bit more than that, but I think  
15 there's an opportunity to kind of look at how that's  
16 working in the homelessness system and whether that can be  
17 replicated in the mental health service system.  
18

19 The other program that I've seen work well is head  
20 leasing programs where a community housing provider holds  
21 the lease and then subleases that to a person with a mental  
22 illness. But what's important with that program, there  
23 needs to be a subsidy that bridges the gap between market  
24 rental CRA and Newstart. I think when someone's on a  
25 disability support pension that subsidy's not as deep, but  
26 I think that requires some Government funding alongside the  
27 head leasing program to make that effective.  
28

29 We've seen people over time successfully manage those  
30 head leasing properties and eventually have the lease  
31 transferred to them away from the community housing  
32 provider and lead into more independent management of the  
33 private rental, so they're two options that are worth  
34 exploring in this space.  
35

36 MS BATTEN: Dr Pollock, did you have anything to add about  
37 how people with mental illness can be maintained in private  
38 rental tenancies?  
39

40 DR POLLOCK: I think what I would add is that, if we're  
41 serious about this, we actually have to do something about  
42 people's financial security and their ability to access  
43 employment. And I know that's kind of a long stretch for  
44 what might help support people in private rental tenancies,  
45 but having a decent income is really important. People  
46 cannot, they simply cannot, manage a private rental tenancy  
47 particularly in metro Melbourne on Newstart: it's just not

1 possible. And I would say even the DSP in metro Melbourne  
2 is actually very, very difficult. So there's a big issue  
3 about financial security and income that I actually think  
4 has to be addressed.

5  
6 In terms of specific supports or specific ways in  
7 which people could be supported to maintain private rental:  
8 a lot of the people with complex mental illness will have  
9 some kind of service contact or service system contact, so  
10 just making sure that tenancy, the role - it's what I said  
11 before, the role that housing plays and the need to support  
12 people through tenancies when they're not very well is well  
13 understood in the mental health workforce most broadly, so  
14 there's early identification and available supports been  
15 put in place, and that will suffice for quite a lot of  
16 people.

17  
18 I think if we look at specific programs, one of the  
19 ones that I've been interested in is the Doorway program  
20 that Wellways has run, and that provides interlinked  
21 tenancy support, psychosocial support, and delivered in  
22 partnership with an Area Mental Health Service so that the  
23 person has a clinical case manager and has their clinical  
24 mental health needs met by the Area Mental Health Service,  
25 and the program has the ability so sort of flex up and down  
26 and to support people through periods of relative wellness  
27 and illness, specifically focused on people in private  
28 rental tenancies.

29  
30 I would say that it requires focused, high quality  
31 support coordination which is, you know, something that  
32 Cathy mentioned before, it's absolutely essential.

33  
34 Then I think beyond that I think, yes, definitely  
35 looking at arrangements that facilitate head leasing and  
36 lead tenant arrangements, and thinking about the ways in  
37 which risk - that there could be some risk sharing between  
38 the State Government and a community housing provider or an  
39 NGO who's willing to take on a lease for somebody with a  
40 complex mental illness. So, it's something that we've  
41 looked at, and particularly with the application of SIL in  
42 private rental, but have stepped away from it because of  
43 the risk of carrying the lease.

44  
45 Then I think it would be great to see some advocacy  
46 for people who are private rental tenants who have an NDIS  
47 package to just be able to use some of their package to pay



1 for their rent during periods of illness.

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So, if I think about what - well, not necessarily what typically happens, but what can happen to people; they can be going along all right, everything fine, working, paying their rent. Then they get unwell, they can't work, they stop looking at their mail, they stop notice, they see the red envelope, they ignore the fact that they haven't paid their rent for three months because it's just been beyond what they can do, they get an eviction notice, that will be enough to tip them into significant illness and a period in hospital.

The stress around maintaining a tenancy, paying the rent, is massive and it's a massive driver of deteriorating mental health. If people with packages could actually use some of that package to tide them through really difficult times I think it would be great. They can't at the moment, but it would be good to really test that with the NDIA.

And likewise, considering some sort of short-term brokerage funds that pays people's rent during a period of illness so that they don't come out of hospital trying to get themselves back together and then immediately hit a huge great big, you know, unpaid rent bill.

MS BATTEN: Thank you. Dr Fotheringham, I'll come back to you.

DR FOTHERINGHAM: Just very briefly, thank you. I just wanted to pick up on one mechanism that both Cathy and Sarah mentioned, head leasing, which I think their comments are really framed as something that a community provider or a community organisation might do, and it's a very positive mechanism, but it's not just the community sector that can do that.

So the Queensland Government, for example, through the Department of Housing and Public Works have for a number of years now, for 20 years or so, run a head leasing program where they will lease properties for particular vulnerable clients as a head leasing arrangement. That was originally designed as a crisis accommodation set-up when there was a shortfall of available social housing, but over the last couple of decades has really evolved into a head leasing arrangement that has operated for people to give stability and safety for, well, typically about two years

1 now rather than the initial framing as a crisis response.  
2 That's called the Community Rent Scheme up in Queensland  
3 and that's something that the Victorian Government could  
4 certainly look at as a model.  
5

6 MS BATTEN: Thank you. Thank you for adding that. My  
7 final question before I hand over to the Commissioners for  
8 their questions is workforce capabilities.  
9

10 All of you have touched on this briefly as you've gone  
11 through in your comments, but I would just like to wrap it  
12 up in a final place.  
13

14 The question is, what is needed to ensure the  
15 workforce has the capability to provide the support needed  
16 for people with mental illness to maintain housing and to  
17 live a contributing life?  
18

19 Ms Humphrey, I'll come to you first.  
20

21 MS HUMPHREY: Look, for me front of mind is sustaining  
22 tenancies practices. I think making inroads to kind of  
23 defining that and articulating that in a practised way  
24 across the various workforces, both in mental health and in  
25 homelessness.  
26

27 Trauma-informed care practices is really fundamental  
28 and what that means both from an organisational perspective  
29 as a support provider, but what does it mean for  
30 individualised care as well.  
31

32 I think increasing knowledge of the NDIS and its  
33 systems and navigating that is really fundamental, both in  
34 mental health services and in non-mental health services.  
35

36 I think somehow within the kind of mainstream service  
37 system is creating information about where to go for  
38 supports. There's kind of that first responder principle,  
39 and this certainly was highlighted in the Family Violence  
40 Royal Commission around, what are the touch points in which  
41 a woman might touch the system and identify that family  
42 violence is a factor for her.  
43

44 In the same respects, how does the mainstream service  
45 system identify when someone is at risk of becoming unwell  
46 or at risk of their housing breaking down, where can we  
47 kind of intercept into that system early, and whether

1 that's with estate agents or GPs or other kind of first  
2 points of contact for people.

3  
4 I think we need to kind of rethink that prevention  
5 activities of keeping people housed and what that means for  
6 workforce development and practices.

7  
8 MS BATTEN: Thank you. Dr Pollock, can I come to you  
9 next.

10  
11 DR POLLOCK: Absolutely agree with what Cathy's just said.  
12 I think that we need systems that actually - we've got a  
13 terrible lack of data, terrible lack of systems that  
14 generate useful data. So, early identification is both a  
15 skills issue, but it's a system issue. It's a, what do you  
16 do once you've identified that somebody's housing is  
17 falling apart? There needs to be systems for actually  
18 collecting that data and multiple points of visibility, I  
19 suppose, for providers to actually see who's vulnerable,  
20 who's at risk.

21  
22 I think we need systems around, not just early  
23 identification when things go wrong, but ways of knowing  
24 who's vulnerable, and I think that applies both to the  
25 specialised systems but also mainstream services.

26  
27 So, if I think about young people, what's the role of  
28 schools, because schools know an awful lot about the young  
29 people and their family circumstances. So, what's the role  
30 of schools in being part of an identification and kind of  
31 early warning for children and young people who might be  
32 vulnerable.

33  
34 I think, when we think about workforce capability, I  
35 think we're talking about multiple workforces, we're  
36 talking about the mental health skills, the mental health  
37 awareness and basic skills of the housing and homelessness  
38 workforce. The mental health workforce, we're talking  
39 about their awareness of the role that housing plays and  
40 knowledge of the housing and homelessness system.

41  
42 Then I think we've got the disability workforce too  
43 that I don't think, you know, as I've said in a number of  
44 different ways already this morning, I don't think the  
45 disability workforce, neither planners, nor LACs, nor the  
46 NGO components of the workforce, I don't think we are  
47 particularly housing aware.

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So I think it's a question of understanding the different workforces that kind of come to bear on this question of housing and mental illness and the different kind of skills that they need.

And there is a very particular and rather difficult question of what you do about private landlords and real estate agents and their skills and understanding of the role that mental illness in particular plays in people's ability to sustain their tenancies.

MS BATTEN: Thank you. Dr Fotheringham, is there anything else that you want to add to the skills that are needed or the workforce capability?

DR FOTHERINGHAM: I guess I was intending to make some of the same remarks that Sarah has already expressed very well, but look, the point of this is, there is not a workforce, there's a multitude of workforces involved in this issue as part of the problem, and as much as there is a challenge for the mental health workforce to be housing aware, there is equally a challenge for the housing workforces to be mental health aware.

I guess there's a number of sort of key providers or key elements of the system to consider. There's DHHS as the public housing provider and the training of public housing tenancy management and so on in mental health matters. There's the community housing sector and the role of CHIAVIC, the Community Housing Industry Association for Victoria as their peak in disseminating information in that space, and there are a number of training providers relevant to both community and public housing through the Australasian Housing Institute and through Swinburne's graduate courses, for example.

I'm less aware of what training is provided for real estate agents by the REIV or other leading agencies in the real estate space, though I think there is probably a workforce there where training and so on is highly relevant.

Then again, also in terms of the mortgage markets, for homeowners, it's entirely possible for someone to go from home ownership to homelessness for mental health reasons, and so, the extent to which the mortgage holders have good

1 systems and good understandings of those challenges and  
2 good ways of supporting is an area to consider as well, so  
3 it's many different workforces to bring in.

4

5 MS BATTEN: Thank you very much for answering all of my  
6 questions, I'll now hand to the Chair to ask you the  
7 Commissioner's questions.

8

9 THE CHAIR: Thank you very much, all of you, for your  
10 contribution today, and I'm going to try and just keep my  
11 one question short because I know this is an area of  
12 particular interest for Professor Fels, and then I'll hand  
13 over to him and other Commissioners.

14

15 I think what's become evident both from your witness  
16 statements and the conversation today, we've got two very  
17 complex service systems: so the mental health service  
18 system, the housing and homeless service system, running in  
19 parallel, and we know about the bidirectional relationship  
20 between mental health and housing and homelessness and what  
21 we need to try and deal with, and your witness statements  
22 do really highlight what we need to do both in terms of  
23 rapid housing responses but also long-term housing for  
24 people with severe mental illness.

25

26 And so, the challenge I guess for me is probably to  
27 the last point you raised about, has anyone - and maybe  
28 starting with you, Dr Fotheringham - do you have a view  
29 about what is a way we can keep this discourse about the  
30 mental health housing homelessness interface dynamic so  
31 that we - because both service systems have very high  
32 levels of unmet demand, probably haven't had enough  
33 planning for the longer term requirements, and we're trying  
34 to future proof the mental health system. Do you have any  
35 suggestions about what might be done to ensure there's a  
36 better planning arrangement in place between mental health  
37 and housing and homelessness services?

38

39 DR FOTHERINGHAM: Thank you for that question. Look, yes,  
40 it is a really profound and complex space, and I'm glad  
41 that you also acknowledge Professor Fels' interest in this  
42 matter because I think it's important to point out that the  
43 work that AHURI's been doing in this space over a number  
44 of years now with Mind Australia, but also with the  
45 National Mental Health Commission before that, and  
46 Professor Fels was instrumental in triggering that body of  
47 work, so I wanted to acknowledge that as a really important

1 foundation for the work that Sarah and I have been doing  
2 since.

3

4 They are quite different systems. This is one of the  
5 spaces in which the way in which governments operate with  
6 policy portfolios starts to run into trouble because, as  
7 issues work across portfolios, the coordination can be  
8 really difficult. I mean, this is a whole-of-government  
9 issue rather than an area for a specific department, a  
10 specific minister, it's one that bridges portfolios and  
11 those are always the most complex: the wicked problems, if  
12 you like.

13

14 It needs a dedicated focus, is my short answer.

15

16 THE CHAIR: I think that whole thing about  
17 whole-of-government responses and how do we actually  
18 translate it into practice is an ongoing challenge for us.

19

20 Professor Fels, can I hand over to you because I know  
21 it is an area of great interest for you.

22

23 COMMISSIONER FELLS: Thank you, Chair, and also like you,  
24 I'd like to thank the three witnesses for their excellent  
25 papers and their contribution this morning, they've all  
26 been most informative and helpful.

27

28 I had three questions. The first one is to  
29 Dr Fotheringham, and in a sense he's partly answered it  
30 already: when we were discussing the question of the NDIA  
31 not really making much room for SDA funding, I just wanted  
32 to sort of remind everyone, or have us reminded, that while  
33 we need to pursue that question, we shouldn't let the State  
34 Government off the hook. They have a really important  
35 responsibility, do they not? I'm trying to make this a  
36 question, Chair.

37

38 Do they not? Do you agree, or do you agree that the  
39 state has got important responsibilities, and I acknowledge  
40 you have actually covered off several of those points  
41 already.

42

43 And also slightly related to that, about the specific  
44 SDA issue, I'd like to comment that I believe one of the  
45 reasons for the limited SDA funding is that there was a  
46 major conflict between the Commonwealth and the states  
47 about who would be responsible and who was responsible for

1 housing, particularly for housing for people with a  
2 disability.

3  
4 The final outcome was a standoff with neither really  
5 being willing to step into the space but with the fact that  
6 previously the State Government spent about \$700 million on  
7 their own disability housing, so that kind of funding got  
8 lobbed into the NDIA and is used for SDA. So, a lot of it,  
9 the problems arise from a lack of Commonwealth and state  
10 agreement on who's responsible for funding for housing for  
11 people with a disability, including people with a mental  
12 health problem.

13  
14 So, do you agree or do you agree that the state has  
15 got pretty significant responsibilities in this area and  
16 along the lines that you've actually indicated, including  
17 making mental health a bit of a higher priority in their  
18 own housing allocations and decisions?

19  
20 THE CHAIR: Well, go for that, Dr Fotheringham.

21  
22 DR FOTHERINGHAM: Thank you for those questions, slightly  
23 leading though they may be.

24  
25 I guess, look, there's a few different things to  
26 unpack there, but the broad theme of what you're talking  
27 about, whether it's NDIA or more broadly, is really about  
28 the Commonwealth State division responsibility for housing  
29 policy, and look, that is a significant issue.

30  
31 It's worth acknowledging actually the changing  
32 relationships or the changing responsibilities over the  
33 last 10 years or so - further, if you like, but really  
34 fundamentally over the last 10 years or so - so really the  
35 life course of the NDIA has operated in two different  
36 contexts in terms of housing policy.

37  
38 So, when NDIA was first formulated we had a National  
39 Affordable Housing Agreement and a National Partnership  
40 Agreement on Homelessness. The NAHA, the National  
41 Affordable Housing Agreement, was a 10-year agreement that  
42 was towards the end of its 10-year lifecycle.

43  
44 The National Partnership Agreement on Homelessness was  
45 much more short-term, typically one year of funding at a  
46 time, and had led to significant uncertainty within the  
47 homelessness sector.

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So, as the housing agreement approached its end and a new agreement was being negotiated between Commonwealth and states, one of the shifts that was undertaken was to roll the homelessness agreement into the housing agreement to have a single agreement that was longer term providing more certainty for the homelessness systems and homelessness funding.

We have that through the National Housing and Homelessness Agreement, it is a different agreement to the previous one in a range of ways and therefore a different policy context to sit alongside the NDIA.

The Commonwealth Government, it's fair to say, has had waxing and waning interests in housing policy and its role in housing policy. Under Prime Minister Abbott there was a very clear declaration that housing and homelessness was not the Commonwealth's remit and they would be stepping back from it. With a change in leadership, the Commonwealth has returned to the space, and quite significantly so. We now have a national housing minister which we haven't had for a number of years, and we have much stronger engagement in both housing and homelessness, both through the Department of Social Services and through Treasury, as well as through the investment in NHFIC as a bond aggregator and distributor of first home buyer loan guarantees and a range of other matters as they've taken responsibility.

So, there was a period in which the Commonwealth was less interested in housing that has now fortunately turned to a much stronger engagement. But the challenge remains that Commonwealth-state negotiations are always fraught and the responsibilities are not necessarily completely clear, nor are the approaches to it consistent from state to state which makes that negotiation more complex.

Look, this happens in a number of policy domains but certainly happens in housing.

AHURI led a policy, a group of senior officials on a study tour of Canada in 2018 where we looked at how their system works for housing and homelessness and they have similar challenges, in that, they have a Federal Government that has moved in and out of housing policy over the last three or four decades. The states or the provinces and



1 territories there have significant roles but have taken  
2 divergent approaches. They have the additional complexity  
3 that their municipal governments, their city governments or  
4 local councils, have taken really active roles as housing  
5 providers which is something we've not seen in this country  
6 that I would like us to see.

7  
8 But to answer your broad question, yes, the  
9 Commonwealth-state complexity there is a significant  
10 impact.

11  
12 THE CHAIR: Thank you. If we can now go to Dr Cockram.

13  
14 COMMISSIONER COCKRAM: Thank you. My question is to  
15 Ms Humphrey, but before I start the question, just again to  
16 say thank you to everyone for the wonderful submissions and  
17 the capacity of this group to better inform the Commission,  
18 so thank you for that.

19  
20 But, Ms Humphrey, you highlighted in your witness  
21 statement issues related to trauma and the importance of a  
22 system that maintains a strong focus on being  
23 trauma-informed.

24  
25 In the context of this Commission's work related to  
26 people living with mental illness I wanted to ask you about  
27 the connection, trauma, substance misuse and abuse, and the  
28 acknowledgment in your submission around increased rates of  
29 personality disorders in groups of people at risk of  
30 housing instability.

31  
32 I'm asking this question because throughout the  
33 Commission's work we have been regularly informed about the  
34 mental health system's challenges in fully supporting  
35 people in a trauma-informed practice, supporting people  
36 with comorbid alcohol and other drug problems, and  
37 supporting people with a diagnosis of personality  
38 disorders.

39  
40 So, I was wondering if you could give us some  
41 directions about how we might think about the  
42 interconnection of those issues for service system design  
43 and service response.

44  
45 MS HUMPHREY: Thank you, Commissioner, for that question,  
46 I think it's a complex response and I probably won't do it  
47 justice in this short timeframe.

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But I think essentially, in order to understand trauma and its impacts on an the individual and then what does that mean from a service system design or an individualised support plan design, you have to understand trauma and what trauma-informed care means, and so, I think fundamentally the service system needs that workforce capability and organisational capability developed to understand what trauma-informed care actually really means.

For us, it's kind of taking that view that we're not necessarily assessing everyone for the impact of trauma, but we take a trauma-informed view that people have been exposed to trauma in some form throughout their lives.

We have data that provides evidence of its prevalence, so we work from the assumption that trauma impact is evident in people's lives. I think for people with personality disorders often that's developed as a result of that traumatic experience often as a child and often in the family home that leads to that particular mental illness challenge for people.

So, you know, there's behavioural contexts and, you know, Sarah spoke about people who can be scary, scary to themselves, scary to the service system, and scary to their support workers, and that's often the people we'll see with personality disorders alongside, you know, really problematic and chaotic substance abuse issues. They're often the group that we're seeing really cycling around and in and out of homelessness and in and out of engagement with the service system.

So, it requires a really thorough understanding of what trauma means in terms of the way the person thinks about their world and how they navigate their world.

I think, when you think about young people and their stages of development, often for someone who's had their first traumatic experience as a young person, that kind of development as an individual is really impacted, and often there's that impact of the brain and what that means; that they're often emotional, still functioning as a 7-year-old, rather than as the adult that's in front of you and what does that mean in the way that we respond to their needs.

I know that's a very short answer but it is quite a

1 complex and multilayered issue, but I think we need as a  
2 service system to understand what it means both from an  
3 organisational perspective and what that means when we are  
4 dealing with people with complex behaviours, that we don't  
5 want a service system that gets scared of them and  
6 therefore bans them from the service system; we need to  
7 understand about regulation, about responsibilities around,  
8 I think, coaching the people to understand the impact of  
9 trauma in their lives and how they navigate their worlds  
10 and the service systems that they come across.

11  
12 THE CHAIR: Thank you very much. I think that point that  
13 you all made about the issue of trauma and the link between  
14 trauma and mental illness, housing, insecurity and  
15 homelessness was very strongly put, as was the fact that  
16 it's very challenging to find safety in those environments  
17 if you don't have stable or secure housing.

18  
19 Professor McSherry, can we go to you.

20  
21 COMMISSIONER McSHERRY: My question was actually on  
22 trauma-informed care too, so I think that's been well  
23 covered. So, again, I just want to thank everyone for such  
24 comprehensive statements and I've certainly learned a lot  
25 today. Thank you.

26  
27 THE CHAIR: Thank you. I think you've also given us lots  
28 of examples of where you think better practice exists and  
29 ideas of where there is the different service delivery  
30 models, different ideas of where we can, together in the  
31 mental health system and the housing and homelessness  
32 sector, have a better response, so we'll certainly be  
33 following up a number of those.

34  
35 I was particularly interested, Ms Humphrey, in your  
36 GreenLight Supportive Housing Program, the rapid housing  
37 responses that you think are important to have within the  
38 system and what that might mean for people with mental  
39 illness.

40  
41 Professor Fels, I think you wanted the last question  
42 before we wrap up, so a question not a statement.

43  
44 COMMISSIONER FELS: Okay, I just wanted to ask Dr Pollock  
45 if she would mind briefly summarising her conclusions,  
46 around about paragraph 30 and following, about the extent  
47 or the numbers needing housing support; that might feed

1 into our general assessment of kind of general needs in  
2 mental health. You've got some numbers there which are  
3 very interesting, could you just briefly summarise them.

4  
5 DR POLLOCK: I'll do my best. So, these are absolutely  
6 estimations, they're a kind of best guess, and I used  
7 largely the SHIP study, the 2010 study, and then figures,  
8 the prevalence figures that are used by the National Mental  
9 Health Commission around severe and persistent - and severe  
10 and persistent episodic.

11  
12 In Victoria I estimate that there are potentially  
13 around 6,000 people who are homeless at any given time with  
14 complex mental illness. But when I added in the prevalence  
15 for people whose complex mental illness was also episodic,  
16 that figure rises to about 11,000. So, we've got somewhere  
17 between 6,000 and 11,000 people who are currently homeless  
18 with mental illness.

19  
20 I think then - and this actually concerned me quite a  
21 lot, was the figures that I estimated around the people who  
22 are currently housed, but they're either housed - they're  
23 either living with family and they don't want to be, or  
24 they're in some form of supported accommodation and that  
25 wouldn't be SIL; the numbers for SIL in Victoria are quite  
26 small.

27  
28 So, there are around 10,000 people who are currently  
29 living in some form of supported accommodation, so SRS or  
30 boarding house or rooming house, and potentially another  
31 10,000 who are living with family where that is not the  
32 desired outcome for either the individual or their family.

33  
34 In terms of what I could work out in terms of who's  
35 actually housed through SIL, somewhere between 500 and 530  
36 people with primary psychosocial disability in Victoria at  
37 the moment. And SDA, I think I said previously, I think  
38 it's about 468 people who have got SDA approved in their  
39 plan, but - I can't remember - somewhere around 250 or 300  
40 people who actually have an SDA property and the majority  
41 of those are in New South Wales and they've come from the  
42 closure of a single psychiatric institution, Morisset.

43  
44 Is that sufficient, Professor Fels?

45  
46 THE CHAIR: Thank you, and I think that was a very  
47 important acknowledgment also in that response that, in

1 addition to those who are homeless, you have a large number  
2 of people who are living really in circumstances that are  
3 not conducive to their mental health, wellbeing and  
4 recovery, nor to those that they're living with, and we've  
5 certainly heard that from both consumers with lived  
6 experience and carers about how stressful sometimes those  
7 circumstances are simply because there's no other choice  
8 and the other choice is possibly homelessness.  
9

10 So, thank you all very much for underscoring the  
11 importance of this issue for us as a Royal Commission, it's  
12 one of our very challenging areas to try and think through  
13 what do we focus on, where do we think there'd be the  
14 greatest impact for improving outcomes for those with  
15 mental illness and housing instability or homelessness, and  
16 that's something that we'll certainly be looking at further  
17 and today's panel discussion has been very helpful in  
18 focusing us on those four directions.  
19

20 Ms Batten, thank you also for facilitating our  
21 discussions today and for leading us through the witness  
22 statements and the materials that were coming through that.  
23

24 Thank you all for your participation and, as I said at  
25 the beginning, I might just in concluding re-record my  
26 introduction after everyone else leaves. So, thank you all  
27 again, it was fabulous, and thank you especially panel  
28 members for putting the effort in during this Covid  
29 environment where everyone's working in such a different  
30 environment but your witness statements are such an  
31 important part of our deliberative process, so thank you  
32 again on our collective behalf.  
33

34 **AT 12.48PM THE COMMISSION WAS ADJOURNED**  
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**Z**

**Zoom [1] - 1:13**

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